

Exhibit E

As filed with the Securities and Exchange Commission on April 11, 2005

SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 20-F

**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934**

For the Fiscal Year ended December 31, 2004

Commission File Number: 001-31368

Sanofi-Aventis

(exact name of registrant as specified in its charter)

N/A

(translation of registrant's name into English)

France

(jurisdiction of incorporation)

174, avenue de France, 75013 Paris, France

(address of principal executive offices)

Securities registered pursuant to Section 12(b) of the Act:

Title of Securities:	Name of each exchange on which registered:
American Depositary Shares, each representing one-half of one ordinary share, nominal value €2 per share	New York Stock Exchange
Ordinary shares, nominal value €2 per share	New York Stock Exchange (for listing purposes only)

Securities registered pursuant to Section 12(g) of the Act:

American Depositary Shares, each representing one quarter of a Participating Share Series A, per value
€70.89 per share (removed from listing and registration on the New York Stock Exchange effective
July 31, 1995).

Securities for which there is a reporting obligation pursuant to Section 15(d) of the Act:

None

**The number of outstanding shares of each of the issuer's classes of capital or
common stock as of December 31, 2004 was:**

ordinary shares: 1,411,404,317

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13
or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period
that the registrant was required to file such reports) and (2) has been subject to such filing requirements
for the past 90 days.

Yes ☒ No

Indicate by check mark which financial statement item the registrant has elected to follow.

Item 17 Item 18 ☒

TABLE OF CONTENTS

Part I		
Item 1.	Identity of Directors, Senior Management and Advisers	1
Item 2.	Offer Statistics and Expected Timetable	1
Item 3.	Key Information	1
	A. Selected Financial Data	1
	B. Capitalization and Indebtedness	3
	C. Reasons for Offer and Use of Proceeds ..	3
	D. Risk Factors	4
Item 4.	Information on the Company	13
	A. History and Development of the Company	14
	B. Business Overview	16
	C. Organizational Structure	57
	D. Property, Plant and Equipment	57
Item 5.	Operating and Financial Review and Prospects	61
Item 6.	Directors, Senior Management and Employees ..	96
	A. Directors and Senior Management	96
	B. Compensation	107
	C. Board Practices	109
	D. Employees and profit sharing	111
	E. Share ownership	113
Item 7.	Major Shareholders and Related Party Transactions	115
	A. Major Shareholders	115
	B. Related Party Transactions	117
	C. Interests of Experts and Counsel	117
Item 8.	Financial Information	118
	A. Consolidated Statements and Other Financial Information	118
	B. Significant Changes	121
Item 9.	The Offer and Listing	121
	A. Offer and Listing Details	121
	B. Plan of Distribution	122
	C. Markets	122
	D. Selling Shareholders	124
	E. Dilution	124
	F. Expenses of the Issue	124
Item 10.	Additional Information	125
	A. Share Capital	125
	B. Memorandum and Articles of Association	127
	C. Material Contracts	139
	D. Exchange Controls	139
	E. Taxation	139
	F. Dividends and Paying Agents	147
	G. Statement by Experts	147
	H. Documents on Display	147
	I. Subsidiary Information	147
Item 11.	Quantitative and Qualitative Disclosures about Market Risk	147
Item 12.	Description of Securities other than Equity Securities	150
Part II		
Item 13.	Defaults, Dividend Arrearages and Delinquencies	151
Item 14.	Material Modifications to the Rights of Security Holders	151
Item 15.	Controls and Procedures	151
Item 16.	[Reserved]	151
Item 16 A.	Audit Committee Financial Expert	151
Item 16 B.	Financial Code of Ethics	151
Item 16 C.	Principal Accountants' Fees and Services	152
Item 16 D.	Exemptions from the Listing Standards for Audit Committees	152
Item 16 E.	Purchases of Equity Securities by the Issuer and Affiliated Purchasers	152
Part III		
Item 17.	Financial Statements	153
Item 18.	Financial Statements	153
Item 19.	Exhibits	240
Annex A.	IFRS Reconciliation Note	A-1

PRESENTATION OF FINANCIAL AND OTHER INFORMATION

The consolidated financial statements contained in this annual report on Form 20-F have been prepared in accordance with French generally accepted accounting principles ("French GAAP"). French GAAP differs in certain significant respects from U.S. generally accepted accounting principles ("U.S. GAAP"). For a description of the principal differences between French GAAP and U.S. GAAP, as they relate to us and to our consolidated subsidiaries, and for a reconciliation of our shareholders' equity and net income to U.S. GAAP, see Note G to our consolidated financial statements included at Item 18, of this annual report.

Our results of operations and financial condition as of and for the year ended December 31, 2004 have been significantly impacted by our August 2004 acquisition of Aventis and certain subsequent transactions (including the merger of Aventis with and into our company in December 2004). The results of operations of Aventis for the period between August 20, 2004 and December 31, 2004 have been included in our consolidated income statement and cash flow statement. This resulted in a significant increase in revenues and significant changes in other financial statement items in 2004 compared to 2003. The assets and liabilities of Aventis are also included in our consolidated balance sheet at December 31, 2004. See "Item 5. Operating and Financial Review and Prospects."

We have prepared unaudited pro forma income statements for 2004 and 2003 that present our results of operations as if the acquisition had taken place on January 1, 2004 and January 1, 2003 respectively, as well as certain other pro forma income statement information described under "Item 5. Operating and Financial Review and Prospects." Because of the significance of the Aventis acquisition, we present certain information in this annual report, such as sales of particular pharmaceutical products, as a percentage of our unaudited pro forma sales, rather than as a percentage of our consolidated sales.

Unless the context requires otherwise, the terms "sanofi-aventis," the "Company," the "Group," "we," "our" or "us" refer to sanofi-aventis and our consolidated subsidiaries. References to "Aventis" refer to Aventis and its consolidated subsidiaries for periods prior to August 20, 2004.

All references herein to "United States" or "U.S." are to the United States of America, references to "dollars" or "\$" are to the currency of the United States, references to "France" are to the Republic of France, and references to "euro" and "€" are to the currency of the European Union member states (including France) participating in the European Monetary Union.

Brand names appearing in this annual report are trademarks of sanofi-aventis and/or its affiliates, with the exception of:

- trademarks used or that may be or have been used under license by sanofi-aventis and /or its affiliates, such as Actonel®, Optinate® and Acrel®, trademarks of Procter & Gamble Pharmaceuticals, Alvesco®, a trademark of Altana Pharma AG, Campto®, a trademark of Kabushiki Kaisha Yakult Honsha, Copaxone®, a trademark of Teva Pharmaceutical Industries, Exubera®, a trademark of Pfizer Products Inc., Genasense®, a trademark of Genta Inc in the United States, Tavanic®, a trademark of Daiichi Pharmaceutical Co. Ltd., Mutagrip®, a trademark of Institut Pasteur, Vasten®, a trademark of E.R. Squibb & Sons, Inc.
- trademarks sold by sanofi-aventis and/or its affiliates, such as Altace® a trademark of King Pharmaceuticals in the United States, Arixta® and Fraxiparine®, trademarks of GlaxosmithKline, Cardizem®, a trademark of Biovail in the United States, Hexilate®, a trademark of CSL Ltd., Ionamin®, a trademark of the Medeva Pharmaceutical Manufacturers Inc. except in Canada and Spain, StarLink®, a trademark of Bayer AG, Suvenyl®, a trademark of Chugai Pharmaceutical Co. Ltd, Synercid®, a trademark of King Pharmaceuticals.
- Cipro® in the U.S. and Aspirine® and Kogenate®, trademarks of Bayer AG, Claritin®, a trademark of Schering Corporation, Ivomec®, Eprinex®, Frontline®, and Heartgard®, trademarks of Merial and Hexavac®, a trademark of Sanofi Pasteur MSD.

PART I**Item 1. Identity of Directors, Senior Management and Advisers**

N/A

Item 2. Offer Statistics and Expected Timetable

N/A

Item 3. Key Information***A. Selected Financial Data*****SUMMARY SELECTED HISTORICAL CONSOLIDATED FINANCIAL DATA OF SANOFI-AVENTIS AND AVENTIS**

The tables below set forth selected consolidated financial data for sanofi-aventis for each of the five years during the period ended December 31, 2004, prepared in accordance with generally accepted accounting principles in France. These financial data are derived from the sanofi-aventis consolidated financial statements, which have been audited by PricewaterhouseCoopers Audit and Ernst & Young Audit, each independent auditors.

You should read the data for 2002, 2003 and 2004 in conjunction with sanofi-aventis's consolidated financial statements (including the notes thereto) in "Item 18. Financial Statements" and "Item 5. Operating and Financial Review and Prospects" in this annual report.

Sanofi-aventis reports its financial results in euros and in conformity with French GAAP, with a reconciliation to U.S. GAAP. Sanofi-aventis also publishes condensed U.S. GAAP information. A description of the principal differences between French GAAP and U.S. GAAP as they relate to sanofi-aventis's consolidated financial statements are set forth in Note F to sanofi-aventis's audited consolidated financial statements included in this annual report.

SELECTED UNAUDITED PRO FORMA CONDENSED FINANCIAL INFORMATION

The following selected unaudited pro forma condensed financial information, which gives effect to the offers and the merger, is presented in euros and reflects the combination of sanofi-aventis and Aventis using the purchase method under French GAAP, as though the public offer and the transaction described in Note D.1 "Impact of the acquisition of Aventis" of the consolidated financial statements in this report had taken place on January 1, 2003 (in the case of the pro forma statement of income for the year ended December 31, 2003) and January 1, 2004 (in the case of the pro forma statement of income for the year ended December 31, 2004).

In addition, the pro forma adjustments reflect the sale to GlaxoSmithKline of sanofi-aventis's interests in Arixtra® and Fraxiparine®, as well as the sale of Campto® to Pfizer Inc and the sale of Aventis Behring to CSL. The pro forma adjustments also include adjustments that have been made to Aventis historical financial statements in order to conform their presentation to the pro forma presentation, and other adjustments, including allocation of the purchase price, which are described in section 5 of the Note D.1 to the consolidated financial statements (Impact of the acquisition of Aventis) included in "Item 18. Financial Statements" in this report.

This selected unaudited pro forma financial information has been derived from and should be read in conjunction with section 5 "unaudited pro forma information" in Note D.1 "Impact of the acquisition of Aventis" included in "Item 18. Financial Statements" in this report. Amounts are stated in euros.

The selected unaudited pro forma financial information is presented for illustrative purposes only and is not necessarily indicative of the operating results or financial condition of the combined entities that would have been achieved had the offers and the merger been completed during the periods presented, nor is the selected unaudited pro forma financial information necessarily indicative of the future operating results or financial position of the combined entities.

<i>(in millions of euros, except per share data)</i>	As of and for the year ended December 31,					Pro forma unaudited,	
	2000	2001	2002	2003	2004	2003	2004
Income statement data: (b)							
<i>French GAAP</i>							
Net sales	5,963	6,488	7,448	8,048	15,043	24,296	25,418
Gross profit	4,521	5,235	6,070	6,620	11,290	18,513	19,376
Operating profit	1,577	2,106	2,614	3,075	(305)	7,254	8,163
Net income	985	1,585	1,759	2,076	(3,610)	977	1,706
Earnings per share: basic (a)	1.35	2.17	2.42	2.95	(3.91)	0.72	1.27
Earnings per share diluted ..	—	—	—	—	—	0.70	1.23
Balance sheet data: (b)							
<i>French GAAP</i>							
Property, plant and equipment, net	1,217	1,229	1,395	1,449	5,886	—	—
Total assets	7,845	9,967	9,459	9,749	76,755	—	—
Long-term debt ..	121	119	65	53	8,638	—	—
Total shareholders' equity	4,304	5,768	6,035	6,323	35,574	—	—
U.S. GAAP Data: (c)							
<i>French GAAP net income</i>	985	1,585	1,759	2,076	(3,610)	—	—
Purchase accounting adjustments	(606)	(445)	(311)	(269)	(100)	—	—
Provisions and other liabilities	(99)	(23)	—	—	28	—	—
Stock based compensation (f)	(5)	(8)	(8)	(50)	(111)	—	—
Revenue recognition – U.S. BMS alliance	(8)	(136)	117	33	—	—	—
Other	104	(42)	31	(16)	(21)	—	—
Income tax effects	221	167	52	91	149	—	—
Subtotal U.S. GAAP adjustments ...	(393)	(487)	(119)	(211)	(55)	—	—
<i>U.S. GAAP net income</i>	592	1,098	1,640	1,865	(3,665)	—	—
<i>French GAAP shareholders' equity</i>	4,304	5,768	6,035	6,323	35,591	—	—
Purchase accounting adjustments	9,479	8,927	8,576	8,267	7,930	—	—
Provisions and other liabilities	110	35	—	—	28	—	—
Revenue recognition – U.S. BMS alliance	(21)	(160)	(35)	—	—	—	—
Other	(168)	(456)	(695)	(635)	(541)	—	—
Income tax effects	(1,563)	(1,365)	(1,282)	(1,219)	(1,376)	—	—
Subtotal U.S. GAAP adjustments ...	7,837	6,981	6,564	6,413	6,041	—	—
<i>U.S. GAAP shareholders' equity</i>	12,141	12,749	12,599	12,736	41,632	—	—
<i>U.S. GAAP earnings per share</i>							
Basic (d)	0.82	1.52	2.30	2.71	(4.03)	—	—
Diluted (e)	0.82	1.51	2.28	2.70	(4.03)	—	—

- (a) Based on the weighted average number of shares outstanding in each year, equal to 731,232,525 shares in 2000, 731,711,225 shares in 2001, 727,686,372 shares in 2002, 702,745,208 shares in 2003, and 923,286,539 in 2004.
- (b) As discussed in Note B.2 to the consolidated financial statements as of, and for the year ended, December 31, 2004 included in "Item 18. Financial Statements" in this report, sanofi-aventis changed its method of accounting for liabilities as of January 1, 2002. The impact of this change on shareholders' equity was €24 million.
- (c) As discussed in Note F 3.1 to sanofi-aventis's consolidated financial statements as of, and for the year ended December 31, 2004, included in "Item 18. Financial Statements" in this report, sanofi-aventis applied Statement of Financial Accounting Standard 142, Goodwill and Other Intangible Assets, as of January 1, 2002.

- (d) Based on the weighted average number of shares outstanding in each period used to compute basic earnings per share, equal to 723,095,521 shares in 2000, 720,726,645 shares in 2001, 714,322,379 shares in 2002, 689,018,905 shares in 2003, and 910,261,740 in 2004.
- (e) Based on the weighted average number of shares outstanding in each period used to compute diluted earnings per share, equal to 726,783,765 shares in 2000, 725,665,764 shares in 2001, 718,041,806 shares in 2002, 691,120,198 shares in 2003, and 914,862,511 in 2004.
- (f) As discussed in Note F.1.C to sanofi-aventis's consolidated financial statements as of, and for the year ended December 31, 2004, included in "Item 18 Financial Statements" in this report, sanofi-aventis voluntarily adopted the fair value recognition provisions of Financial Accounting Standard 123, Accounting for Stock-Based Compensation, as of January 1, 2003.

EXCHANGE RATE INFORMATION

Exchange Rates

The following table sets forth, for the periods and dates indicated, certain information concerning the exchange rates for the euro from 2000 through March 31, 2005 expressed in U.S. dollar per euro. The information concerning the U.S. dollar exchange rate is based on the noon buying rate in New York City for cable transfers in foreign currencies as certified for customs purposes by the Federal Reserve Bank of New York (the "Noon Buying Rate"). We provide the exchange rates below solely for your convenience. We do not represent that euros were, could have been, or could be, converted into U.S. dollars at these rates or at any other rate. For information regarding the effect of currency fluctuations on our results of operations, see "Item 5. Operating and Financial Review and Prospects."

Selected Exchange Rate Information

	<u>Period- end Rate</u>	<u>Average Rate (1)</u>	<u>High</u>	<u>Low</u>
	(U.S. dollar per euro)			
2000	0.94	0.92	1.03	0.83
2001	0.89	0.89	0.95	0.84
2002	1.05	0.95	1.05	0.86
2003	1.26	1.14	1.26	1.04
2004	1.35	1.25	1.36	1.18
Last 6 months				
2004				
October	1.27	1.25	1.28	1.23
November	1.33	1.30	1.33	1.27
December	1.35	1.34	1.36	1.32
2005				
January	1.30	1.31	1.35	1.30
February	1.33	1.30	1.33	1.28
March	1.30	1.32	1.35	1.29

- (1) The average of the Noon Buying Rates on the last business day of each month during the relevant period for year average, on each business day of the month for monthly average.

On April 6, 2005, the Noon Buying Rate was \$1.29 per euro.

B. Capitalization and Indebtedness

N/A

C. Reasons for Offer and Use of Proceeds

N/A

D. Risk Factors

Important factors that could cause actual results to differ materially from our expectations are disclosed in this annual report, including without limitation the following risk factors and the factors described under "Cautionary Statement Regarding Forward-Looking Statements". In addition to the risks listed below, we may be subject to other material risks that are not currently known to us or that we deem immaterial at this time.

Risks Relating to Our Company

The integration of the new Group's activities presents significant challenges that may result in the combined business not operating as effectively as expected or in the failure to achieve some or all of the anticipated benefits of the business combination.

The benefits and synergies expected to result from the combination of sanofi-aventis and Aventis will depend in part on whether the operations of Aventis can be integrated in a timely and efficient manner with those of sanofi-aventis. Sanofi-aventis faces significant challenges in consolidating sanofi-aventis' functions with those of Aventis, and integrating the organizations, procedures and operations of the two businesses. The integration of the two businesses is complex and time-consuming, and management must dedicate substantial time and resources to it. These efforts could divert management's focus and resources from other strategic opportunities and from day-to-day operational matters during the integration process. Failure to successfully integrate the operations of sanofi-aventis and Aventis could result in delay or the failure to achieve some or all of the anticipated benefits from the business combination, including synergies and other operating efficiencies, and could have an adverse effect on the business, operating results, financial condition or prospects of sanofi-aventis.

We incurred substantial debt in connection with the acquisition of Aventis, which limits our business flexibility and requires us to devote cash resources to debt service payments.

In connection with our acquisition of Aventis, our consolidated financial debt increased substantially, because we incurred new debt to finance the cash portion of the acquisition consideration, and because our consolidated financial debt includes the debt incurred by Aventis prior to the acquisition. As a result, our consolidated financial debt was €16.0 billion as of December 31, 2004, and our consolidated net financial indebtedness (financial debt less cash and cash equivalents and short term investments — excluding treasury shares held in connection with stock option plans) was €14.2 billion, as of that date, compared to consolidated financial debt of €0.4 billion and a positive consolidated net cash position of €2.4 billion as of December 31, 2003. As a result, we must make significant debt service payments to our lenders. Our current debt level could restrict our ability to engage in additional transactions or incur additional indebtedness. For more information on our debt, please see "Item 5. Operating and Financial Review and Prospectus — Liquidity and Capital Resources" in this annual report.

We depend on the United States market for a significant part of our current and future operating results. A failure to continue our strategy of profitable operations in that market could adversely affect our business, results of operations, financial condition or prospects.

We may not achieve our growth strategy if we do not maintain and continue to profitably expand our presence in the United States, the world's largest pharmaceuticals market. We have identified the United States, which accounted for 34.5% of our pro forma net sales in 2004, as a potential major source of continued future growth and plan to capitalize on our direct presence in the United States in the coming years to build our leadership in this market. We face a number of challenges in maintaining profitable growth in the United States, including.

- The success of the management organization that we have established in the United States.
- The targeting of new products and customer markets.
- The fact that the United States market is dominated by major U.S. pharmaceutical companies.
- Potential changes in health care reimbursement policies and possible cost control regulations in the United States.
- Exposure to the euro-dollar exchange rate.

We depend on third parties for the marketing of some of our products. These third parties may act in ways that could harm our business.

We commercialize some of our products in collaboration with other pharmaceutical companies. For example, we currently have a major collaborative arrangement with Bristol-Myers Squibb for the marketing of Plavix® and Aprovel® in the United States and several other countries, and co-marketing agreements with Procter & Gamble Pharmaceuticals for the osteoporosis treatment Actonel® and Teva for Copaxone®, as well as an agreement with Merck & Co., Inc. for the distribution of vaccines in Europe. We also have alliances with several Japanese companies for the marketing of our products in Japan. See “Item 4. Information on the Company — Business Overview — Marketing and Distribution.” When we commercialize our products through collaboration arrangements, we are subject to the risk that certain decisions, such as the establishment of budgets and promotion strategies, are subject to the control of our collaboration partners, and that deadlocks may adversely affect the activities conducted through the collaboration arrangements. For example, our alliances with Bristol-Myers Squibb are subject to the operational management of Bristol-Myers Squibb in some countries, including the United States. We cannot be certain that our partners will perform their obligations as expected. Further, our partners might pursue their own existing or alternative technologies or product candidates in preference to those being developed or marketed in collaboration with us.

The manufacture of our products is technically complex, and supply interruptions caused by unforeseen events can delay the launch of new products, reduce sales and adversely affect operating results and financial condition.

Many of our products are manufactured using technically complex processes requiring specialized facilities, highly specific raw materials and other production constraints. Our vaccine products in particular are subject to the risk of manufacturing stoppages or the risk of loss of inventory because of the difficulties inherent to the sterile processing of biological materials and the potential for the unavailability in adequate amounts of raw materials meeting our standards. The complexity of these processes as well as strict company and government standards for the manufacture of our products and subject us to the risk of production problems, the investigation and remediation of which can cause production delay and additional expense, lost inventories or sales, and with respect to new products, can potentially delay a planned launch.

We depend on third parties for the manufacturing of the active ingredients for some of our products and for a substantial portion of our specialized components and raw materials.

Third-Party Manufacturing of Active Ingredients. Although our general policy is to manufacture the active ingredients for our products ourselves, we subcontract the manufacture of some of our active ingredients to third parties, which exposes us to the risk of a supply interruption in the event that our suppliers experience financial difficulties or are unable to manufacture a sufficient supply of our products. The manufacture of the active ingredients for Eloxatine® and Xatral® and part of the manufacture of the active ingredient for Stilnox® is currently done by third parties, as is a part of the chemical activity linked to Lovenox®. Additionally, under our collaborative arrangement with Bristol-Myers Squibb, pharmaceutical production of Plavix® and Aprovel® is conducted partly in sanofi-aventis plants and partly in Bristol-Myers Squibb plants.

Availability of Specialized Components/Raw Materials. Third parties supply us with a substantial portion of our specialized components and raw materials. Some raw materials essential to the manufacture of our products are not widely available from sources we consider reliable — for example, there are a limited number of approved suppliers of heparin. Heparin is used in the manufacture of Lovenox®. See “Item 4. Information on the Company — Business Overview — Production and Raw Materials” for a description of these outsourcing arrangements.

Although we have not experienced any problems in the past, if disruptions were to arise either in the third-party supply of active ingredients or raw materials, this would impact our ability to sell our products in the quantities demanded by the market, and could damage our reputation and relationships with our customers. Even though we aim to have backup sources of supply whenever possible, including by manufacturing backup supplies of our principal active ingredients at a second or third facility when practicable, we cannot be certain they will be sufficient if our principal sources become unavailable. Any of these factors could adversely affect our business, operating results or financial condition.

Our collaborations with third parties expose us to risks that they will assert intellectual property rights on our inventions or fail to keep our unpatented technology confidential.

We occasionally provide information and materials to research collaborators in academic institutions or other public or private entities, or request them to conduct tests to investigate certain materials. In all cases we enter into appropriate confidentiality agreements with such entities. However, those entities might assert intellectual property rights with respect to the results of the tests conducted by their collaborators, and might not grant licenses to us regarding their intellectual property rights on acceptable terms.

We also rely upon unpatented proprietary technology, processes, know-how and data that we regard as trade secrets and protect them in part by entering into confidentiality agreements with our employees, consultants and certain contractors. We cannot be sure that these agreements or other trade secret protections will provide meaningful protection, or if they are breached, that we will have adequate remedies. You should read “Item 4. Information on the Company — Business Overview — Patents, Intellectual Property and Other Rights” for more information about our patents and licenses.

Claims relating to marketing practices could adversely affect our business, results of operations and financial condition.

The marketing of our products is heavily regulated, and failure to comply fully with applicable regulations could result in civil or criminal actions against us, and under some circumstances potential disqualification from participation in government health programs. Sanofi-aventis and certain of its subsidiaries are under investigation by various government entities, and are defendants in a number of lawsuits, relating to antitrust and/or pricing and marketing practices, including an investigation of alleged underpayment of rebates to U.S. federal health programs. See Note D.20.1(b) to our consolidated financial statements included at Item 18 of this annual report. Because many of these cases allege substantial unquantified damages, including treble damages, and seek significant punitive damages and penalties, it is possible that any final determination of liability could have a material adverse effect on our financial position, results of operations and cash flows.

Fluctuations in currency exchange rates could adversely affect our results of operations and financial condition.

Because we sell our products in numerous countries, our results of operations and financial condition could be adversely affected by fluctuations in currency exchange rates. We are particularly sensitive to movements in exchange rates between the euro and the U.S. dollar, the British pound, the Japanese yen, and to a lesser extent to currencies in emerging countries. In 2004, 34.5% of our pro forma net sales were realized in the United States. While we incur expenses in those currencies, the impact of these expenses does not fully offset the impact of currency exchange rates on our revenues. As a result, currency exchange rate movements can have a considerable impact on our earnings. When deemed appropriate, we enter into transactions to hedge our exposure to foreign exchange risks. These efforts, when undertaken, may fail to offset the effect of adverse currency exchange rate fluctuations on our results of operations. For more information concerning our exchange rate exposure, see “Item 11. Quantitative and Qualitative Disclosures About Market Risk.”

Risks Relating to Our Industry

We must invest substantial sums in research and development in order to remain competitive, and we may not fully recover these investments if our products are unsuccessful in clinical trials or fail to receive regulatory approval.

To be successful in the highly competitive pharmaceutical industry, we must commit substantial resources each year to research and development in order to develop new products. In 2004 on a pro forma basis, we spent €3,961 million on research and development, amounting to approximately 15.6% of our pro forma net sales. Our ongoing investments in new product launches and research and development for future products could produce higher costs without a proportionate increase in revenues.

The research and development process is lengthy and carries a substantial risk of product failure. If our research and development does not yield sufficient new products that achieve commercial success, our future operating results may be negatively affected.

The research and development process typically takes from 10 to 15 years from discovery to commercial product launch. This process is conducted in various stages, and during each stage there is a substantial risk that we will not achieve our goals and will have to abandon a product in which we have invested substantial amounts.

For example, in order to develop a commercially viable product, we must demonstrate, through extensive pre-clinical and human clinical trials, that the pharmacological compounds are safe and effective for use in humans. There is also no assurance that favorable results obtained in pre-clinical trials will be confirmed by later clinical trials, or that the clinical trials will establish sufficient safety and efficacy data necessary for regulatory approval. In the first quarter, we had 128 compounds in pre-clinical and clinical development in our targeted therapeutic areas, of which 48 were in phase II or phase III clinical trials. For additional information regarding clinical trials and the definition of the phases of clinical trials, see “Item 4. Information on the Company — Business Overview — Research and Development.” There can be no assurance that any of these compounds will be proven safe or effective, or that they will produce commercially successful products.

After completing the research and development process, we must invest substantial additional resources seeking to obtain government approval in multiple jurisdictions, with no assurance that approval will be obtained. We must obtain and maintain regulatory approval for our pharmaceutical products from the European Union, the United States and other regulatory authorities before a given product may be sold in its markets and thereafter. The submission of an application to a regulatory authority provides no assurance that the regulatory authority will grant a license to market the product. Each authority may impose its own requirements, including requiring local studies, and may delay or refuse to grant approval, even though a product has already been approved in another country.

In our principal markets, the approval process for one or more indications of a new product is complex and lengthy, and typically takes from six months to two years from the date of application depending on the country. Moreover, if regulatory approval of a product is granted, the approval may place limitations on the indicated uses for which it may be marketed. A marketed product is also subject to continual review even after regulatory approval. Later discovery of previously unknown problems may result in marketing restrictions or withdrawal of the product (as has occurred recently with respect to a number of products marketed by other major pharmaceutical companies), as well as an increased risk of litigation. In addition, we are subject to strict government controls on the manufacture, labeling, distribution and marketing of our products. Each of these factors may increase our costs of developing new products and the risk that we may not succeed in selling them successfully.

If we are unable to protect our proprietary rights, we may not compete effectively or operate profitably.

It is important for our success that we be able to effectively obtain, maintain and enforce our patents and other proprietary rights. Patent law relating to the scope of claims in the pharmaceutical field in which we operate is a continually evolving field of law and can be subject to some uncertainty. Accordingly, we cannot be sure that:

- new, additional inventions will be patentable;
- patents for which applications are now pending will be issued or reissued to us; or
- the scope of any patent protection will be sufficiently broad to exclude competitors.

Additionally, third parties may challenge the validity of the patents issued or licensed to us, which may result in the invalidation of these rights and the loss of the related sales. We currently have approximately 49,000 patents, patent licenses and patent applications worldwide. Patent litigation is subject to substantial uncertainty, and we cannot be sure how much protection, if any, will be provided by our patents if we attempt to enforce them and they are challenged in court or in other proceedings. Additionally, patent protection is limited in time. To the extent effective patent protection of our products is not maintained, these products will become exposed to competition from generic products. The entry of a generic product into the market typically is followed by a substantial decline in the brand-name product’s sales volume and revenues.

Significant challenges to our proprietary rights include:

In the first half of 2002, two pharmaceutical companies, Apotex and Dr. Reddy's Laboratories, each filed an Abbreviated New Drug Application, or ANDA, with the U.S. Food and Drug Administration, or FDA, seeking to market a generic form of Plavix® in the United States and challenging certain U.S. patents relating to Plavix®. Subsequently, in August 2004, Teva filed an ANDA challenging one of the U.S. patents relating to Plavix®. Similar challenges have been instituted in Canada and Scotland. For additional information regarding ANDAs, see "Item 4. Information on the Company — Business Overview — Regulation." We have filed suit against Apotex, Dr. Reddy's Laboratories and Teva for infringement of our patent rights. See "Item 8. Financial Information — Consolidated Financial Statements and Other Information — Information on Legal and Arbitral Proceedings" and Note D.20.1(c) to our consolidated financial statements included in this annual report at Item 18. The Plavix® patent rights are material to our business, and if we were unsuccessful in asserting them or they were deemed invalid, any resulting introduction of a generic version of Plavix® in the U.S. would reduce the price that we receive for this product and the volume of the product that we would be able to sell and could materially adversely affect our business, operating results and financial condition.

As a reference, the pro forma developed sales of Plavix® in 2004 in the United States amounted to €2,289 million out of total worldwide pro forma developed sales of sanofi-aventis of €28,529 million. "Pro forma developed sales" is a non-GAAP financial measure we use to demonstrate the overall trends for our products in the market, and which consists of pro forma sales of our products, excluding sales to our alliance partners, and of sales that are made through our alliances and which are not included in our consolidated sales. In 2004, sanofi-aventis's share of the profits of the Plavix® and Avapro® joint ventures managed by Bristol-Myers Squibb in North America amounted to €581 million, versus €436 million in 2003. See "Item 5. Operating and Financial Review and Prospects — Results of Operations — Year Ended December 31, 2004 Compared to Year Ended December 31, 2003" herein for additional information as well as a derivation of "pro forma developed sales."

We have been notified that seven generic pharmaceutical companies are seeking FDA approval to market generic versions of Allegra® products in the U.S. We have filed patent infringement lawsuits against all of these companies. In June 2003, we were notified that both Amphastar Pharmaceuticals and Teva Pharmaceuticals were seeking approval from the FDA for generic versions of Lovenox® and are challenging the patent protection of this product. We are also involved in litigation challenging the validity, assertibility or enforceability of patents related to a number of other products, and challenges to other products may be expected in the future. See "Item 18. Financial Information—Consolidated Financial Statements and Other Information—Information on Legal and Arbitral Proceedings" and Note D.20.1(c) to our consolidated financial statements included in this annual report at Item 18 for additional information.

Our patents may be infringed, or we may infringe the patents of others.

Our competitors may infringe our patents or successfully avoid them through design innovation. To prevent infringement, we may file infringement claims, which are expensive and time consuming. Policing unauthorized use of our intellectual property is difficult, and we may not be able to prevent misappropriation of our proprietary rights. This risk is increased by the growth in the number of patent applications filed and patents granted in the pharmaceutical industry.

Product liability claims could adversely affect our business, operating results and financial condition.

Product liability is a significant commercial risk for us, and may become a more significant risk as we expand in the United States (where product liability claims can be particularly costly). Substantial damage awards have been made in certain jurisdictions against pharmaceutical companies based upon claims for injuries allegedly caused by the use of their products. In addition, some pharmaceutical companies have recently withdrawn products from the market in the wake of significant product liability claims or concerns about potential claims. Although we maintain insurance to cover risk of product liability, we cannot be certain that our insurance will be sufficient to cover all potential liabilities. Further, there is a general trend in the insurance industry to exclude certain products from coverage and to reduce insured limits for liabilities arising through joint ventures. Substantial product liability claims, if successful, could adversely affect our business, operating results and financial condition.

Use of biologically-derived ingredients may face consumer resistance, which could adversely affect sales and cause us to incur substantial costs.

In line with industry practice, we manufacture our vaccines and many of our prescription pharmaceutical products with ingredients derived from animal or plant tissue. Most of these products cannot be made economically, if at all, with synthetic ingredients. We subject our products incorporating these ingredients to extensive tests and believe them to be safe. There have been instances in the past where the use of biologically derived ingredients by sanofi-aventis or its competitors has been alleged to be an actual or theoretical source of harm, including infection or allergic reaction, or instances where production facilities have been subject to prolonged periods of closure because of possible contamination. Such allegations have on occasion lead to damage claims and increased consumer resistance to such ingredients. A substantial claim of harm caused by a product incorporating biologically derived ingredients or a contamination event could lead us to incur potentially substantial costs as a result of, among other things, litigation of claims, product recalls, adoption of additional safety measures, manufacturing delays, investment in consumer education, and development of synthetic substitutes for ingredients of biological origin. Such claims also could generate consumer resistance, with a corresponding adverse effect on sales and operating results.

We face uncertainties over pricing of pharmaceutical products.

The commercial success of our products depends in part on the conditions under which our products are reimbursed. Price pressure is strong due to:

- price controls imposed by governments in many countries; and
- the tendency of governments and private health care providers to favor generic pharmaceuticals.

Price pressure is considerable in our two largest markets, Europe and the United States, which represented 43.8% and 34.5%, respectively, of our pro forma net sales in 2004. Changes in the pricing environments in the United States or Europe (on an individual country basis) could have a significant impact on our revenues and operating profits. See “Item 4. Information on the Company — Business Overview — Pricing” for a description of certain regulatory pricing systems that impact our Group.

Our results may also be adversely affected by parallel imports, a practice by which traders exploit price differentials among markets by purchasing in lower-priced markets for resale in higher-priced markets.

Changes in marketing status or competitive environment of our major products could adversely affect our operating results.

In some cases, pharmaceutical products face the risk of being switched from prescription drug status to over-the-counter (OTC) drug status by national regulatory authorities. OTC drugs may not benefit from the same reimbursement schemes and are generally priced significantly lower than brand-name prescription drugs. The competitive environment of our products could also be adversely affected if generic or OTC versions of competitors’ products were to become available.

For example, Allegra®, which generated pro forma net sales of €1,502 million in 2004, may face additional price pressure in the United States if it is switched to over-the-counter (OTC) status. In May 2001, a majority of the members of an FDA joint Advisory Committee recommended that Allegra® and two competing drugs be “switched” from prescription to OTC status as requested in a citizen petition filed by certain managed care organizations. The FDA has not publicly acted on the citizen petition, and it is not possible to predict what action, if any, the FDA might take. In November 2002, the FDA approved a change from prescription to OTC status for Claritin®, a drug competing with Allegra®, and OTC versions of Claritin® now compete with Allegra® in the United States.

Risks from the handling of hazardous materials could adversely affect our operating results.

Pharmaceutical manufacturing activities, such as the chemical manufacturing of the active ingredients in our products and the related storage and transportation of raw materials, products and wastes expose us to various risks, including:

- fires and/or explosions from inflammable substances;
- storage tank leaks and ruptures; and
- discharges or releases of toxic or hazardous substances.

These operating risks can cause personal injury, property damage and environmental contamination, and may result in:

- the shutdown of affected facilities and
- the imposition of civil or criminal penalties.

The occurrence of any of these events may significantly reduce the productivity and profitability of a particular manufacturing facility and adversely affect our operating results.

Although we maintain property, business interruption and casualty insurance that we believe is in accordance with customary industry practices, we cannot assure you that this insurance will be adequate to cover fully all potential hazards incidental to our business. For more detailed information on environmental issues, see “Item 4. Information on the Company — Business Overview — Health, Safety and Environment.”

Environmental liabilities and compliance costs may have a significant adverse effect on our operating results.

The environmental laws of various jurisdictions impose actual and potential obligations on our Group to remediate contaminated sites. These obligations may relate to sites:

- that we currently own or operate,
- that we formerly owned or operated, or
- where waste from our operations was disposed.

These environmental remediation obligations could significantly reduce our operating results. In particular, our accruals for these obligations may be insufficient if the assumptions underlying these accruals prove incorrect or if we are held responsible for additional, currently undiscovered contamination. Any shortfalls could have a material adverse effect on our operating profits. See “Item 4. Information on the Company — Business Overview — Health, Safety and Environment” for additional information regarding our environmental policies.

Furthermore, we are or may become involved in claims, lawsuits and administrative proceedings relating to environmental matters. Some current and former sanofi-aventis subsidiaries have been named as “potentially responsible parties” or the equivalent under the U.S. Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (also known as “Superfund”), and similar statutes in the United States, France, Germany, Brazil and elsewhere. As a matter of statutory or contractual obligation, we and/or our subsidiaries may retain responsibility for environmental liabilities at some of the sites our predecessor companies, our subsidiaries and we demerged, divested or may divest. We are currently involved in litigation with Albemarle and Rhodia over environmental remediation at several sites no longer owned by the Group. An adverse outcome in any of these might have a significant adverse effect on our operating results. See Note D.20.1(d) to the consolidated financial statements included at Item 18 of this annual report.

Finally, stricter environmental, safety and health laws and enforcement policies could result in substantial costs and liabilities to our Group and could subject our handling, manufacture, use, reuse or disposal of substances or pollutants to more rigorous scrutiny than is currently the case. Consequently, compliance with these laws could result in significant capital expenditures as well as other costs and liabilities, thereby adversely affecting our business, operating results or financial condition.

Risks Relating to an Investment in our Shares or ADSs**Foreign exchange fluctuations may adversely affect the U.S. dollar value of our ADSs and dividends (if any).**

As a holder of ADSs, you may face exchange rate risk. Our ADSs trade in U.S. dollars and our shares trade in euros. The value of the ADSs and our shares could fluctuate as the exchange rates between these currencies fluctuate. If and when we do pay dividends, they would be denominated in euros. Fluctuations in the exchange rate between the euro and the U.S. dollar will affect the U.S. dollar amounts received by owners of ADSs upon conversion by the depositary of cash dividends, if any. Moreover, these fluctuations may affect the U.S. dollar price of the ADSs on the New York Stock Exchange, whether or not we pay dividends in addition to the amounts, if any, that you would receive upon our liquidation or upon the sale of assets, merger, tender offer or similar transactions denominated in euros or any other foreign currency other than U.S. dollars.

If you hold ADSs rather than shares it may be difficult for you to exercise some of your rights as a shareholder.

As a holder of ADSs, it may be more difficult for you to exercise your rights as a shareholder than it would be if you directly held shares. For example, if we offer new shares and you have the right to subscribe for a portion of them, the depositary is allowed, in its own discretion, to sell for your benefit that right to subscribe for new shares instead of making it available to you. Also, to exercise your voting rights, as a holder of ADSs, you must instruct the depositary how to vote your shares. Because of this extra procedural step involving the depositary, the process for exercising voting rights will take longer for you, as a holder of ADSs, than for holders of shares. ADSs for which the depositary does not receive timely voting instructions will not be voted at any meeting.

Sanofi-aventis's two largest shareholders own a significant percentage of the enlarged share capital and voting rights of sanofi-aventis.

At December 31, 2004, Total and L'Oréal, our two largest shareholders, held approximately 12.7% and 10.1% of our issued share capital, accounting for approximately 21.4% and approximately 17.1%, respectively, of the voting rights of sanofi-aventis. See "Item 7. Major Shareholders and Related Party Transactions — Major Shareholders — Shareholders' Agreement".

To the extent these shareholders continue to hold a large percentage of our share capital and voting rights, Total and L'Oréal will remain in a position to exert heightened influence in the election of the directors and officers of sanofi-aventis and in other corporate actions that require shareholders' approval. Continued ownership of a large percentage of the share capital and voting rights of sanofi-aventis by these two principal shareholders, affiliates of whom may also continue to be members of the sanofi-aventis board of directors, may have the effect of delaying, deferring or preventing a future change in the control of sanofi-aventis and may discourage future bids for sanofi-aventis other than with the support of these shareholders.

Sales of our shares that will be eligible for sale in the near future may cause the market price of our shares or ADSs to decline.

Total and L'Oréal are not, to our knowledge, subject to any contractual restrictions on the sale of the shares they hold in our company. Sales of a substantial number of our shares, or a perception that such sales may occur, could adversely affect the market price for our shares and ADSs. See "Item 10. Additional Information — Share Capital — Shares Eligible for Future Sale" for a more detailed description of the eligibility of our shares for future sale.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report contains forward-looking statements. We may also make written or oral forward-looking statements in our periodic reports to the Securities and Exchange Commission on Form 6-K, in our annual report to shareholders, in our proxy statements, in our offering circulars and prospectuses, in press releases and other written materials and in oral statements made by our officers, directors or employees to third parties. Examples of such forward-looking statements include:

- projections of operating revenues, net income, net earnings per share, capital expenditures, positive or negative synergies, dividends, capital structure or other financial items or ratios;
- statements of our plans, objectives or goals, including those relating to products, clinical trials, regulatory approvals and competition;
- statements about our future economic performance or that of France, the United States or any other countries in which we operate; and
- statements of assumptions underlying such statements

Words such as “believe,” “anticipate,” “plan,” “expect,” “intend,” “target,” “estimate,” “project,” “predict,” “forecast,” “guideline,” “should” and similar expressions are intended to identify forward-looking statements but are not the exclusive means of identifying such statements.

Forward-looking statements involve inherent risks and uncertainties. We caution you that a number of important factors could cause actual results to differ materially from those contained in any forward-looking statements. Such factors, some of which are discussed under “Risk Factors” above, include but are not limited to:

- the impact of our acquisition of Aventis;
- our ability to continue to maintain and expand our presence profitably in the United States;
- the success of our research and development programs;
- our ability to protect our intellectual property rights;
- the risks associated with reimbursement of healthcare costs and pricing reforms, particularly in the United States and Europe; and
- trends in the exchange rate and interest rate environments.

We caution you that the foregoing list of factors is not exclusive and that other risks and uncertainties may cause actual results to differ materially from those in forward-looking statements.

Forward-looking statements speak only as of the date they are made. Other than required by law, we do not undertake any obligation to update them in light of new information or future developments.

Project highlights

LCM development programs for our marketed products are described above in the “–Products–Pharmaceutical Activity”.

Cardiovascular and Thrombosis

Certain of our principal compounds in the fields of Cardiovascular and Thrombosis currently in phase IIb, phase III or phase IIb clinical trials are described below.

- **Dronedaron** (SR33589, atrial fibrillation; phase III). The current reference anti-arrhythmic is still amiodarone, which we have marketed since the late 1960s under the brand name Cordarone®. With dronedarone, a potential successor to Cordarone®, our goal is to develop a new treatment that is at least as effective as amiodarone, but with improved tolerance. The first indication being developed for dronedarone is the prevention of recurrences of atrial fibrillation, the most common cardiac rhythm disorder. The usual treatment for acute atrial fibrillation is an external electric shock to the heart, which is then generally followed by a medicinal anti-arrhythmic agent to avoid recurrences, which are extremely common. The EURIDIS (Europe) and ADONIS (North and South America, Australia and South Africa) phase III trials, involving 1,245 patients with atrial fibrillation have confirmed the good efficacy and safety of dronedarone as an anti-arrhythmic drug, particularly with the absence of any pro-arrhythmic effect. Based on these data, a submission file is currently being prepared and is planned to be discussed with health authorities.
- **Idraparin** sodium (SR34006, thromboembolic events; phase III). Idraparin sodium is an injectable synthetic pentasaccharide, selectively inhibiting coagulation factor Xa. Idraparin sodium has a demonstrated potency and long duration of action that may permit a therapeutic regimen consisting of only one injection per week in humans. Two phase III programs, VAN GOGH and AMADEUS, both of which started in 2003, are ongoing. The VAN GOGH program is studying idraparin sodium in the long-term treatment of thromboembolic events in patients suffering from deep-vein thrombosis or pulmonary embolism. The AMADEUS program is studying idraparin sodium in the prevention of thromboembolic events associated with atrial fibrillation.
- **SSR149744C** (atrial fibrillation; phase IIb). Besides the improved tolerability as compared to amiodarone, SSR149744C is expected to be active with a once-a-day dosing. The targeted indication for SSR149744C is atrial fibrillation. SSR149744C entered phase IIb in December 2004.
- **SR123781** (thromboembolic events; phase IIb). SR123781 is an injectable synthetic oligosaccharide, inhibiting both coagulation factors Xa and IIa. It is a potent antithrombotic drug with a shorter duration of action than idraparin and it is currently being studied in Phase IIb in patients with arterial thrombosis.
- **Otamixaban** (XRP0673, thromboembolic events; phase IIb). Otamixaban is an injectable non-saccharidic synthetic direct inhibitor of coagulation factor Xa. It exhibits a fast on- and offset of action and represents a promising approach for the initial treatment of ACS.

Metabolic Disorders

Our main compounds currently in late-stage development for metabolic disorders are described below.

- **Acomplia™** (rimonabant, SR141716, metabolic syndrome and weight management, smoking cessation; phase III). Rimonabant is the first in a new class of therapeutics called selective CB-1 receptor blockers. CB-1 receptors were found first in the brain and identified now in several human tissues, including adipocytes. They are part of the endocannabinoid system, which is critically involved in the regulation of body mass and body weight, lipid metabolism and insulin resistance.

Rimonabant is completing a phase III program in obesity, metabolic syndrome and related disorders like type 2 diabetes and dyslipidemia (the RIO program. rimonabant in obesity). This phase III program started in 2001 and is composed of 4 large studies in more than 6,600 overweight patients with co-morbidities and obese patients including severely obese patients (BMI

over 40). These studies evaluated doses of 5 mg and 20 mg of rimonabant. Results are available from the following completed studies: RIO Lipids in patients with previously untreated dyslipidemia treated with rimonabant or placebo for one year; RIO North America in overweight patients with co-morbidities or obese patients including severely obese patients treated for one year in this study, patients receiving the active treatment were re-randomized for a second year to rimonabant or placebo; and RIO Europe in overweight patients with co-morbidities or obese patients including severely obese patients treated for two years continuously.

Results from the first three studies at one year demonstrated a significant, robust and consistent weight loss (6.3 to 6.9 kg at 20 mg versus 1.5 to 1.8 kg for placebo) and decrease of waist circumference, a marker of visceral fat (6.1 to 7.1 cm at 20 mg versus 2.4 to 2.5 cm in placebo), throughout all the studies. 48% to 58% of patients lost 5% of their weight with 20 mg versus 20% in the placebo group. 25% to 32% of patients on 20 mg lost 10% of their weight versus 7.2% to 8.5% in the placebo groups.

Many obese and overweight persons seen in clinical practice are readily recognized as having multiple cardiovascular risk factors. These individuals are considered to suffer from metabolic syndrome, a condition associated with a core metabolic disorder close to insulin resistance. Patients with metabolic syndrome are at increased risk of coronary heart disease, other diseases related to plaque buildups in artery walls (e.g., stroke and peripheral vascular disease) and type 2 diabetes. The NCEP ATPIII panel identified six components of this condition: abdominal obesity, atherogenic dyslipidemia, raised blood pressure, insulin resistance with or without glucose intolerance, pro-inflammatory state and pro-thrombotic state. The panel recommended the use of the following clinical criteria for the diagnosis of metabolic syndrome: waist circumference over 88 cm in women and 102 cm in men, TG higher than or equal to 150 mg/dl, HDL less than 50 mg/dl in women and 40 mg/dl in men, blood pressure higher than 130/85 mmHg and fasting glucose more than 110 mg/dl. A patient meeting three out of five of these criteria is considered to suffer from metabolic syndrome. In the RIO program 40% to 80% of the patients, depending on the study, presented with metabolic syndrome at baseline. In addition to the consistent and robust data summarized above, rimonabant, compared to placebo, statistically decreased the number of patients meeting the criteria of metabolic syndrome at the end of one year of treatment, significantly improved insulin sensitivity, increased HDL (good cholesterol) and decreased triglyceride levels while being well tolerated.

Results at two years from RIO North America demonstrated statistically significant weight loss and decrease of waist circumference while providing improvement of metabolic parameters over the second year compared to patients switching treatment to placebo at the end of the first year. The results at two years from RIO Europe, presented at the American College of Cardiology in March 2005 have further confirmed the efficacy and safety of rimonabant in the long term together with an improvement in cardiovascular risk factors demonstrated over the second year.

The key results of those important studies were presented at major international conferences throughout the year 2004, such as the American College of Cardiology in March 2004 (STRATUS US and RIO Lipids), the European Congress of Cardiology in August 2004 (RIO Europe one year data), and the meeting of the American Heart Association, November 2004 (RIO North America one and two years data).

A fourth study, RIO Diabetes, was completed in 2004. This study included patients with type 2 diabetes mellitus, including overweight patients with co-morbidities or obese patients (including severe obesity), treated for one year. These data will complete the profile of rimonabant in type 2 diabetics. Results from RIO Diabetes will be available in the first half of 2005.

Rimonabant is also being evaluated in smoking cessation in a separate phase III program. The endocannabinoid system is also involved in the sensitivity to positive re-enforcers such as nicotine. Thus CB-1 receptor blockers such as rimonabant may help patients to quit smoking. The medical importance of helping patients to quit smoking is evidenced by the fact that smoking is the second most frequent cause of death and the fourth common risk factor for diseases worldwide. It has been identified as the major preventable risk factor for cardiovascular disease,

cancer, chronic obstructive pulmonary disease (COPD) as well as type 2 diabetes mellitus. According to the World Health Organization, approximately 1.3 billion people currently smoke worldwide, and cigarette smoking is considered to be responsible for an estimated 5 millions premature deaths each year. While 70% of smokers indicate that they would like to abandon cigarette smoking, only 30% will actually try to quit, and only 3% of attempts will be successful. Moreover smoking cessation is associated with significant weight gain which is a major reason for not trying to quit cigarette smoking. Rimonabant is completing a phase III program in smoking cessation and maintenance (the STRATUS program: Studies with Rimonabant And Tobacco Use). This phase III program started in 2002 and is composed of the following three large studies including more than 5,500 patients: STRATUS US, STRATUS EU and STRATUS WW. In the two short term studies STRATUS US (United States) and STRATUS EU (Europe), patients were treated for 10 weeks and were allowed to smoke at study entry but were given a target quit date at day 15. Efficacy was measured as abstinence from tobacco during the last four weeks of the 10 weeks treatment. Results of STRATUS US are available and showed that rimonabant doubled the odds of quitting cigarette smoking versus placebo while maintaining a well tolerated profile. Moreover, patients on placebo gained more than 2 pounds (1.1kg) while patients treated with the drug lost around just over half a pound (0.3kg). The third long-term study STRATUS WW (worldwide) evaluated the maintenance of abstinence at one year. In this study patients who were abstinent after 10 weeks of treatment with the drug were re-randomised on rimonabant or placebo for one year. Finally, in STRATUS-WW study, rimonabant administered at the dose of 20mg/day was significantly more effective than placebo in the maintenance of abstinence up to one year after smoking cessation, with a good safety profile.

Simultaneous regulatory submission in the United States and Europe for all the indications of rimonabant is planned for first half of 2005 and launch is planned for 2006.

In addition, to the phase III program, a large phase IIb program has been designed and initiated for rimonabant in 2004. Finally, rimonabant entered phase IIb in Japan.

- **Exubera®** (HMR4006, insulin-dependant diabetes mellitus; submitted) a rapid-acting inhaled insulin that is being co-developed with Pfizer, has been submitted for regulatory approval in Europe and in the United States.

Oncology

The sanofi-aventis oncology portfolio represents a broad spectrum of novel agents with a variety of mechanisms of action for treating cancer and/or cancer side-effects, including cytotoxic agents, anti-mitotic agents, bioreductive agents, receptor antagonists, anti-angiogenic agents, anti-vascular agents, cancer vaccines as well as supportive care therapies. Our principal compounds in the field of oncology currently in clinical trials are described below.

- **Tirapazamine** (SR 259075, head and neck cancer; phase III). Tirapazamine is an anti-cancer agent activated under hypoxic conditions to promote the destruction of resistant hypoxic cells. This innovative mechanism of action is likely to diminish the rate of relapse in tumors associated with hypoxia (i.e. head and neck cancer). Phase III trials on tirapazamine in combination with cisplatin and radiation in head and neck cancer are ongoing. Exploratory Phase I and II studies in other tumors associated with hypoxia are also ongoing.
- **Meclintertant** (SR 48692, small cell lung cancer; phase IIb). Meclintertant is a specific neurotensin receptor antagonist that arrests the growth of tumors (as small cell lung cancer) which are dependent on neurotensin. Currently, meclintertant is being studied in patients with small cell lung cancer as maintenance therapy following standard treatment with cisplatin / etoposide. Additional clinical studies are planned for 2005.
- **Xaliproden** (chemotherapy induced neuropathy; phase III). Xaliproden is an orally active neurotrophic agent which is currently being studied in phase III trials for the treatment of chemotherapy-induced neuropathy.

Exhibit F

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

Event Date/Time: Mar. 01. 2005 / 9:00AM ET

THOMSON
★

streetevents@thomson.com

617.603.7900

www.streetevents.com

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

CORPORATE PARTICIPANTS

Jean-Francois Dehecq

Sanofi Aventis - Chairman & CEO

Hanspeter Spek

Sanofi Aventis - EVP Pharmaceutical Operations

Jean-Claude Leroy

Sanofi Aventis - SVP & CEO

Gerard Le Fur

Sanofi Aventis - Senior EVP Science & Medical Affairs

CONFERENCE CALL PARTICIPANTS

Paul Major

Redburn - Analyst

Jo Walton

Lehman Brothers - Analyst

Graham Parry

Merrill Lynch - Analyst

Stephen Putnam

Credit Suisse Asset Management - Analyst

Michael Leacock

Nomura - Analyst

PRESENTATION

Operator

Good day ladies and gentlemen. Welcome to today's Sanofi Aventis 2004 full-year results conference call. As a reminder, today's call is being recorded. At this time I would like to turn the call over to your host today, Mr. Jean-Francois Dehecq, Chairman and Chief Executive Officer. Please go ahead, sir.

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

Hanspeter Spek will give you some explanation on the financial figures, and then Gerard Le Fur will give you his view around our portfolio, and then I will conclude with some figures for '05.

So Hanspeter, that's you.

Hanspeter Spek - *Sanofi Aventis - EVP Pharmaceutical Operations*

Thank you. Yes. Good day to you out there. It is a great pleasure, and it's even described that I present for the first time the results of Sanofi Aventis.

Now what has achieved this Company, this new Company in the first year of its existence in terms of sales, if I could have the first slide please. Thank you. So you see we have achieved additional sales of 2b and you see further that this means a growth of 10% in terms of consolidated sales, and 12.3% in terms of developed sales.

The first to see is that the 15 leading products -- these strategic products have been growing by 17.8%. And that we have achieved, at least for the time being, the other products, which represent still nearly 10b of sales. So we have achieved at least a certain stagnation with those products, plus 0.2%, as you see from the chart.

Further worth noting is the fact that there is a good equilibrium between the sales coming out of the U.S., representing approximately 35%, and the sales coming out of Europe, 43%. And if we could have the next slide please.

This growth means we have outgrown the pharmaceutical market which is, of course, for the first year, not so bad. In more qualitative terms, you see from the chart that we have also achieved the largest growth amongst all major pharmaceutical companies.

And more in detail in terms of consolidated sales, we have achieved additional [uses], approximately the same magnitude as Pfizer. But then you see if you look to the large part, in the creating sales coming especially from Plavix, you see that we have clearly outperformed the market.

Further words to be noted is the fact that we have been growing nearly everywhere better than the market. And last but not least, again, our excellent performance in the United States, where we are now for 4 consecutive years the fastest-growing pharmaceutical company overall.

Next please. How could this have been achieved? Mainly by a very, very rapid integration. We took over the keys of Aventis only in August. And so it is probably fair to say that this has been 1 of the fastest integration processes of all.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

How did we do it? First of all, by a very clear but not to say simple, strategic concepts which, in terms of products, is based on [2-folds] for strategic products. And those strategic products represent today 11 global plans. And within those 11, 8 products are blockbuster products, selling more than 1b per year. And it's fair to say that some more products are on the way to become blockbusters.

The second [part] in terms of so-called base business. The products which represent, as I said before, approximately 10b, which means those traditional products, which are the [indiscernible], which are the basis for this business, which we will give more attention than in the past. And you have seen there the first insight there.

Another element is in the strategic choices put in place has been the model no small countries and also no small products. So country-wise we give the same attention to every market, knowing that the structural problem is the same. Of course, recognizing the magnitude of problems and also opportunities, of course, largely differs.

Last but not least, this is a strategic business, which is built upon pharmaceuticals, but we give a very, very strategic value to the vaccines and also for the future today on a relatively small level to the generics, which you see are an important component, especially in the future development for pharmaceutical companies.

As said before, we have put this in place very rapidly, already during the fourth quarter 2004. All managers have been nominated. We have put things right in terms of future locations of our subsidiaries. And consequently we have announced closing approximately 70 subsidiaries in the world. And the effects of those announcements translates in the first quarter of 2005, where we see the first people go subsequent to this decision. But we also see that we very much succeed to maintain the people who are important to continue to drive this business further.

So we can say today that as of January 1, which was one of our major objectives, the post a network of subsidiaries that is totally functional and is out there to achieve our targets for the ongoing year.

Other important elements of the restructuring, together with the merger across the sales force. We have today a sales force of 33,000 people, with approximately 8,000 people in the United States. And 8,000 people means today that we have the second-largest sales force in the U.S., only topped by

Pfizer, which is currently employing approximately 9,000 people.

The other advantage is that we [have gained] some excellent other countries, such as Japan, where we employ now 1,500, and also China, where was aim for having 1,000 people.

We have aimed also for some [quickies] in terms of synergies. We have put Plavix and Lovenox promotion together. And we are expecting quite some upside from those. And we have also put Aprovel together with those people selling, and those the beginning of the second half of 2004 for ramipril in the Aventis side of the company, because we want to take advantage of the huge franchise in the cardiovascular field.

Last but not least, as you see from the chart, we have combined 2 sales forces in the U.S. which were both leader in certain qualitative terms. There is the fact that Aventis has been the most successful company in terms of access [access]. And Sanofi-Synthelabo has been the most successful company in terms of effectiveness of sales forces. So we feel we have good reason to hope that combining both forces will even drive the quality of our field force in the U.S. further.

Last but not least, the portfolio. The portfolio of blockbusters, and not only blockbusters. It is also a portfolio in which Plavix, Lovenox, Taxotere, Eloxatine, Ambien and Allegra are therapy captains, which means the first in their respective class.

I said before, we have currently 8 blockbusters in our portfolio, 2 more to come. We believe that Lantus and Copaxone will be those products, heading then up to a portfolio of 10 products selling more than 1b this year.

I think it's fair to point out that we are very content with the close of those strategic products, as you see from the chart. Except Allegra and Tritace, both suffering difficult circumstances. Tritace, of course, the out of patent situation. Allegra, this specific situation of antihistamines in the U.S. Except those 2 products, all other products show high two-digit growth figures 60%, 29% for Plavix, and [so forth]. So it's fair to say that this portfolio is in excellent shape.

Now more in detail. First of all, Plavix. Plavix has over-passed 4b of sales this year, 35% growth. And, as you see from the chart, Plavix is also a blockbuster outside the United States, which gives a certain light to the ongoing patent litigation.

We have very, very interesting imminent views ahead of us at the ACC convention, as the results of CLARITY and COMMIT

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

will be presented. Of course, we cannot give you any details. But I think it's fair to indicate that we are rather confident that those two studies will support an additional indication for Plavix, which is then an indication in the myocardial infarction, which would give additional room for growth.

Further important to indicate our total confidence in the product, supported by continuously large life cycle management program, including 30,000 patients. You see there it's CHARISMA, upcoming in terms of results by 2006. But we may have another indication coming from that, ACTIVE is 14,000 patients, which is another potentially additional indication in atrial fibrillation.

So Lovenox, as [main product], is still the largest product in the portfolio in terms of consolidated sales. Sales were close to 2b. A product many, many years on the market in [perfect health], growing by 22%, still driven by the 2 major indications, prophylaxes and unstable angina. Both indications are leveraged only to approximately 40% to 50%. So it is clear that this product still has a very, very bright future ahead of it, despite the fact that it has far biggest market share today, ranking between 40% and 90%. As you see from the chart, the product is the market leader in 8 out of 9 major markets.

Aprovel. Our objective with Aprovel has been to grow with the market. Very clearly we are not out there with the ambition to dominate this market. We leave this ambition to others. And we can say that we have achieved this ambition of growing this market, from 21%, getting close to 1.5b. You see that especially in Europe the development of the product continues to be strong.

I mentioned before, we hope to get synergies from the ramipril franchise within the former Aventis field forces. And you see from the chart that also in this product there is massive investment in terms of lifecycle management. You see the impressive figures. Most of those [sides] are also indication seeking.

Lantus and Apidra, another domain of the new Group, which is the treatment of diabetes. Lantus, an insulin, has become market-leader in the United States, in Germany and in France. And this is a growth rate of 80%. So it's fair to say that also this product is on a very, very positive way.

We have a number of interesting studies also where we will continue to benefit from. We have just launched in the United States a new device called Opticlik, which will further ease the application of the product. And then there is the imminent

launch of Apidra, a fast-acting insulin, which is aimed to complete our portfolio, our offer in this field as from 2005 on a country-by-country basis.

Now, the next important step in terms of product launches, of course, is rimonabant. Acomplia, Gerard Le Fur will give you more details on the clinical result. So in summary, we are perfectly on track to deposit the file as foreseen in the second quarter of 2005.

And as more, we are getting close to the deposit of the file. Of course, we are getting closer to the final positioning. And as you see from the little graph, the positioning will take place in the triangle of abdominal obesity, risk factors in the cardiovascular field and finally, of course, cardiovascular diseases.

We expect that in the next couple of days 2 important communications at the American Cardiology Convention, if those communications are out, they will add to the more than 100 publications on Acomplia since 2001. And last but not least, yes, we have initiated additional clinical trials in the prevention of cardiovascular disease with the evident primary endpoint.

It is too early to give you an indication for pictures of this product, but I thought it may be of help to discuss the target a little bit the market. As you have seen from the first chart, the key orientation is abdominal obesity. And you see that, for example, in the American population, this means today approximately 91m people in a potential target group.

Also we would not aim, at the beginning at least, for this enormous target group. You see that in the sub-populations, if I take, for example, obese patients presenting a risk factor which already has been treated or others who have not been treated, it gets to very, very large populations. And this is, of course, part of our optimism for the upcoming commercial and economic success of this product, which should become available by the end of 2005 or very early in 2006.

The latest launch of Aventis has been Ketek, an antibiotic, which had been previously launched in France where the product very rapidly became market leader. The product is doing well -- even very well in the U.S. The product has been the most successful launch of an antibiotic overall so far in the United States. Sales, [I now confirm], is +67%. Still on a small level. But we believe that 2005 will be another successful year with even more as we start to have a very significant season for antibiotics in Europe, but also in the United States.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

Ambien, Stilnox is approaching the end of its first lifecycle. The product goes off patent in October 2006. So if we get a pediatric extension 6 months later, then in 2007. The product is behaving extremely well, with 15% growth in 2004, achieving 1.4b. You see that of course the largest part of the sales comes from the United States, where the product has a fabulous market share of 86%.

We have deposited the success of Ambien, Ambien CR in June 2004. We have an action date with the FDA in April 2005. And so if everything goes well we expect to launch this product by mid-2005. And then the second life of Ambien should start. We will have everything in place to try the replacement of Ambien by Ambien CR to a maximum speed. We feel quite encouraged also by the fact that our 2 competitors have continuously delayed to report, so we have sufficient time to make the necessary effort to make a maximum shift to the new form, which will then give us another longer period of protection.

Actonel, another product which became a blockbuster in 2004. This is product developed by Proctor & Gamble. We market it jointly all over the world. You see that also in terms of consolidated sales, the development of the product has been fabulous, with 60% growth. This is through all over where the product is being marketed. We achieved all over the highest share of new patients, which makes us very, very optimistic, also for a continuous growth of the product in 2005 and further.

And now the domain of the new Company of exceptional strength is then oncology. Taxotere. First of all, you see a relatively modest growth for our sales of plus 11% in 2004, up to 1.4b. The main reason for this was a not very well balanced reimbursement system for this kind of product in the U.S. This is an effect of the past. The system has been reviewed by January 3, 2005. Today Taxoid(ph) and its generics, and Taxotere have the same conditions. And we see a very, very interesting, very exciting uptake since January 1 in our U.S. sales.

Besides, the product has a cornerstone tradition in the treatment of the metastatic breast cancer and also in the treatment of the hormone resistant cancer of the prostate. There are new indications to come, as you see from the chart, which is the gastric cancer and cancer of the head and neck. So together we see a harmonization of the reimbursement. We are very, very optimistic that this product will have high 2-digit growth in 2005 onward.

Second product, second blockbuster in oncology, which really is a totally unique situation for our portfolio, that is Eloxatin. Eloxatin had another year of superb growth, 57%. 1.2b of sales. We are market leader with this product in first and in second line.

For the future I think it is very encouraging to see that Eloxatin is the preferred combination partner of Avastin, which means our predictions that the new generation of products will be add-on products is coming through. And that was for Taxotere. Eloxatin as well became a cornerstone of the respective therapy, which is, of course, the treatment of colon cancer.

2 words on our presence in vaccines. As said before, we give a lot of importance to this presence as an important strategic part of our offers in healthcare. You see the sales of 1.6b for 2004, which does not include our sales through the joint venture with Merck.

The business has very much benefited in 2004 from a growth in the flu vaccines, which contributed 33% of growth. And that's a very important use. Finally there has been, at the end of 2004, the deposit of a new vaccine, Menactra, which is indicated in the prevention of bacterial meningitis, a very, very traumatic disease. And we have significant expectations in this respect.

As you see from the chart, we had once again a leading position. We are market leader in vaccines, with a market share of 25%, followed by GSK and Merck. And with the new products in preparation and underway to be launched, we are convinced that we are able to further expand this market-leading position.

To sum it up, after the first year of 2004, what can be said? We have a unified sales force of 33,000 people. If I could have the next slide please. We have a fantastic portfolio of 8 blockbusters to date. 2 more products to be coming in blockbuster size is in a very, very short period of time. We have a base portfolio which we already now have obtained to become more or less stable. We always have stressed that [these uses] is mandatory.

We have very, very strong therapy-leading positions, especially in cardiovascular but also in oncology. We are very proud to say that for example in the United States, 1 out of 2 patients suffering from cancer can benefit from 1 of our products.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

And last but not least, we have Acomplia and [indiscernible], which means there is an immediate source of further resource for continued growth. This growth has been excellent in 2004. You see that Sanofi Aventis has been the most important growth driver overall in pharmaceutical industry in terms of absolute growth and in terms of relative growth.

So, to make it very short, I feel everything is in place to have a continued success in 2005. Thank you.

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

Thanks Hanspeter. Jean-Claude?

Jean-Claude Leroy - *Sanofi Aventis - SVP & CEO*

Thank you Jean-Francois. Good day ladies and gentlemen.

I try to comment on the 2004 financial results now. And I will do that mainly through the proforma adjusted net figures -- net income, and proforma adjusted P&L, as I'm sure you have realized that this is the main proper way of reporting on the financial condition of the Company. And especially when it comes to my comparison with the 2003 year on the full-year basis. I will be back on this 1 with a little bit of methodology. But to begin with I will give a few words about purchase price and purchase price allocation.

Purchase price to begin with. This is a 52.1b acquisition with a cash component of 15.9b, and we will look at that a little bit later.

If we come now on the allocation of the purchase price -- next please, next shot please. This is a rather complicated chart. But I will only draw your attention on some figures which are included, and mainly those which are recorded in blue.

To draw your attention on the main valuation, to begin with, the valuation of R&D, which is the 5b. And second on the identifiable -- what we call identifiable intangible assets at fair value, we are talking of products currently in the market for 32b. And the third next important 1, which is the goodwill. The remaining value of the allocation, which is 24.67b(ph). And as you can see, the most important part of the valuation is done on [untenable] effects.

Maybe a fourth 1, which are the deferred taxes, which are referred there for 12b, just to remind you because we have

had a lot of questions on this 1. That unfortunately we are not talking here of any saving -- cash saving of taxes. It's purely accounting entries which are attached to the principal, for example, for the identifiable intangible assets. So unfortunately no cash savings for taxes as through this allocation.

The thing which I think is of interest is the fact that these values -- these final allocations which have been done with specialists, I am talking, for example, of Standard & Poor's, is rather close to the valuation we provided to you with during the year 2004 through both the F4 and the [e-document] through the operation. So there is no surprise, if I may say so, between what we provided you with and the final allocation.

I would also just remind you that this balance sheet has not yet got definitive figures. I mean by that that the closing of the opening balance sheet is going to appear for August 20, 2005. And if there were adjustments to be made during that time, that would be made accordingly.

And to finish with, I would say that these values are going to be either amortized or impaired during a large number of years. And that is the reason for which, since the beginning of the launch of the operation, we can through utilizing the adjusted net income concept, which I remind you is an easy 1 to understand. It's purely the net income and the French GAAP, less first significant purchase accounting treatment, which are to be eliminated, and less restructuring costs. And along this presentation, that is what I'm going to follow up through all lines of the P&L.

In the meantime, just because this acquisition has been done August 20, we have had to present proformas. We will remind you the rules again, to finish with I will go with the proforma adjusted statement. We are doing as if this acquisition had been done on January 1, 2003, with the acquisition date for the financial cost has been burdened to the P&L from the beginning of the year 2003.

We have eliminated these products, their contribution, the capital gain which have been sold because of the authorities decided so on the -- sorry, Arixtra, Fraxiparine and Camppto. Obviously we've eliminated also the Aventis Behring, which was divested.

This is purely technical. Let me come back to the adjusted net income concept and comment on the P&L -- adjusted P&L of the Company. So between 2003 and 2004, 12 months aggregation of these 2 companies. The sales level, Hanspeter

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

told you that the consolidated -- so-called consolidated run at 10% increased base. You know that there has been impact -- currency impact. There has also been perimeter impact. Some products were divested. So the so-called published pace was plus 4.6% at 25.4b in sales. And it's going to be the comparison when we look at the charges which are going to come afterwards.

To begin with, the gross profit. You can see that we are making a 76.2% gross margin rate, which is exactly the same as we did in 2003. The reason for that is first that we have some negative impact in 2004, which are related to the -- what we call the pharmaceutical contribution, which is the money which is taken by the local health authorities. It's a minus 0.4% impact on the sales.

On the contrary, we had positive sides, like the royalties, mainly on Plavix and Avapro, which increased. And this is an impact -- a positive impact by 0.3 percentage points when the product mix is also positive by another 0.1%.

When we go to the next line, we go to the R&D. R&D, with booking of about 4b of expense in 2004, which is a little bit less than the year before, 2.6%. I have to mention that this does include milestone payments. And we have observed a decrease of milestones in 2004 as compared to 2003, roughly 120m of milestones in 2003, as compared to 40m in 2004. And as you can see, this is mainly the difference between the 2 years.

More importantly, R&D does represent 15.6% of sales in 2003 or '04. And you may recall that we said a year before that R&D would be more or less between 15 and 16% of the sales.

As far as the selling and general expenses are concerned, we are talking of close to 7.7b of expenses in this area. 30% of the sales. It is a plus 2.2%. This is the main area where we have resisted the synergies in 2004. And this is mainly due in the fact that since the announcement of the operation, I am talking now of the end of January 2004, the 2 groups kept their employment policy rather strictly since that date.

The next line might be a little bit technical. The other operating income and expense. Just a word on it. This is where we share profit with our partners. I am talking about Bristol-Myers Squibb, I am talking about Proctor & Gamble, [and action] in Actonel. So we had the remaining part of the profits, which are split. What can I say? This is a plus 100m as compared to 2003. And I can split that increase rather

equally between -- from 1 part, Plavix and Avapro and the rest from the Actonel alliance with Proctor & Gamble.

Maybe I should have said, as a technical matter, but in the past this was not the way Aventis did account it for, so you may be surprised. But just to simplify your reading of the Actonel accounting with this book, let me just say that this is exactly the same way as the BMS alliance in Avapro and Plavix has been done for years in the ex-Sanofi-Synthelabo.

So we are down to the operating profit. And you can see 32% of the sales, an increase by 12.5%. Then we go to more technical lines, but some -- these are some comments.

I will begin by the financial incomes before the exceptional and be back on the exceptional afterwards. Financial income shows a little bit of an improvement. The main reason being that we have encountered, in 2004, a small reduction in the interest rate as well as an increase in the cash-flow position, just because the Company did generate cash flows.

Now, in addition to that, but on the other side around, this is the line item in which we do register the impact of these companies in which we hold a stake and which are lifted from the [statement], such as the [indiscernible] to [buy the] companies. And in 2004 there was a negative impact by 76m, when in 2003 the balance was rather equal.

As I mentioned before in this line item of the -- in financial items, when we provide with proformas, that does mean that the acquisition date has been accounted for since January 1, 2003. So both 2003 and 2004 are burdened with the financial cost of the equivalent debt.

Next, the exceptional items. I shouldn't even comment on that because we are showing small figures - minus 41m in 2003, plus 29m in 2004. Nonetheless it is worth giving some comment. As you can see first there are these gains from disposal of receipt(ph). I should say disposal on products. And this is a result of the old policy, which was run by Aventis before the acquisition, and which drove to a level of capital gain which is equivalent in 2004 and 2003.

In addition to that, there were also this restructuring, which were conducted by Aventis before the acquisition. And there were some remaining costs in 2004, 140m, as well as there will be at the end of them with a small amount in 2005.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

Aventis also did encounter some defense costs in 2004, 156m. So this is a component of the line item. And the last 1, which is rather important in 2003, 221m charges in 2003 as compared to -- 63m sorry, in 2004, charges which are related to these activities which were divested since. And I am talking mainly of Aventis Crop Science, of Clariant and the Animal Nutrition business.

If we go now to the next 1, this is first to begin with on the P&L, the income tax. You see a rather different income tax rate between 2003 and 2004, 28.1% in 2003 to be compared with 31.5% in 2004. Let's just say a few words, that 31.5%, which is the 2004 rate, is the current rate. We have some positive exceptionals in 2003.

Income from equity investees net, you see there is a swing between 2003 and 2004. And 2003, which was a loss by 150m, to be compared to the positive 176m positive contribution in 2004. In 2003 there were some negative ones. Rhodia, which was accounted for under the equity method in 2003. No more in 2004, just because a large stake was divested to [indiscernible]. And this was a negative impact.

Another 1 was Dystar, our chemical company, which was divested the beginning of 2004. And this was the Wacker chemical company, also negative contribution in 2003. The 3 of them did represent more than 300m negative contribution which we didn't encounter obviously in 2004. But I would say that the 2004 situation is rather normal.

So all of that drives us to a proforma net income -- and adjusted proforma net income of 5247m, up to close to 18%. And on an EPS basis, 3.89 in 2004, up to 18.2% as compared to the 3.39 per share in 2003.

When we looked at the 2003 and 2004 accounts, you see that there were a lot of pluses and minuses along the lines. And we asked ourselves the question, are the 2004 accounts -- the 2004 P&L a good basis for the future. So we did make the exercise -- the exercise, and to look inside the P&L to try and determine and to see if the basis was the correct basis.

As you have seen, there were these gains on disposal of, as I said, some products, which did represent more than 400m in 2004. And you know that we have said and determined that selling the product to make capital gain was not the kind of policy we wanted to follow up.

Now there are also some negatives which have been taken into account in the 2004 books, and which we feel are not at all reproducible in 2005, so which should be cancelled, if I may say so. And I have already mentioned some of them, like the defense costs, restructuring costs. I have said that it is going to be the end of it in 2005. Obviously the charge relating to divested activities. The quasi-equity instruments just because we refinanced.

To say it in a few words, we can say, I think that the plus and the minuses, that the net performance, the net adjusted result of 2004 is a good basis for all of us to see how the Company is going to perform in the future.

A few words about the cash position now. You know that we started from net debt, so this is a negative sign of 2.4b beginning of 2004, end of 2003. We have seen in the first slide that we didn't count an acquisition debt of 15.9b. What for the rest? The rest is a free cash flow of the year 2004 which is a positive by 4.1b.

What does it come from? Mainly obviously from the cash flow from operations, a positive 5.5b contribution. In addition to that, we had also some disposals of assets net of taxes of 1.4b. What are these? Mainly these are comprised of these disposals which were made according to the Brussels requirement. I am talking again of Arixtra, Fraxiparine and Campto, which represent half of this amount.

In addition to that there has been the disposal of Aventis Behring for a little bit less than 500m. And these products, like Fandarapril(ph), as Marco(ph) generics, Synosis(ph) and so on, which were met before the acquisition and which did represent also a little bit less than 500m.

The other way around, as you may recall, there has been that reimbursement to a buyer on the Aventis Crop Science disposal by a little bit over 300m. These amounts are included. These are positive 1.4b disposals, as I said.

The other way around, there were expenses -- expenditures, I should say, in the CapEx by 1.4b. And dividend for the same amount as that. We did generate in 2004 a little bit over 4b. And as you can see, this is just about 1 fourth of the acquisition debt.

The final -- the ending situation is a debt by 14.2b at the end of 2004, which is a gearing of close to 40%. But saying

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

that we have been capable of generating 1 fourth of the acquisition debt in 2004 reinforces our belief and our saying that we are going to reimburse the acquisition debt within 5 years.

Just a glance at the consolidated books. And I remind you that that acquisition was done on August 20, 2004, which does mean that these books do comprise 12 months of the ex-Sanofi-Synthelabo, plus 4 months and 10 days of Aventis. But all the entries which are related to the purchase price accounting. You see that it does end up with a loss by 3.6b. We did the same kind of exercise to come up to the consolidated net income by the same rules I explained with on the adjusted net income.

If I go directly on the earning per share -- consolidated earning per share, you see that this is a 3.86 per share. I have to comment on this 1. The first is that for Sanofi-Synthelabo shareholders, the earning per share in 2003 was 2.95. So this is a 30% increase between 2003 and 2004. And this is the reason for which we said from day 1 that it would be an equities operation for them.

The second I would say is of importance also. You have seen that the adjusted net income on a 12-month -- plus 12-month basis Aventis with Sanofi, we show that at 3.89 per share EPS. On the consolidated basis we are close to the same amount. So I guess that it brings some credibility to the way we have constructed these figures. And so that we can follow up the way that Sanofi Aventis is performing though the adjusted figures.

I will not talk very much about transition to IFRS today. We have an appointment together on April 14. Let's just give you the impact on the bottom line, which, as you can see, is a decrease of the bottom line by 222m. The main component being the stock options, which is an amount by 240m and which drives us to the IFRS bottom line. That, if I can have the next slide please, thank you, from the 5247m in under French GAAP is going to show up with 5025m under IFRS. Or 3.77 per share, which is going to be the basis for which the Chairman is going to give the guidance for 2005 later on.

To finish up, the next 1. Thank you. A word about the dividend which we are going to bring to the AGM this year. We are going to propose a dividend of 1.20, which is an increase by 17.6%. This is to be compared to the 18.2% increase in the

EPS. We said before, during the operation, that we would follow up the Sanofi policy.

As you can see the payout is either 31 or 32, depending on which reference you [look at]. It is a little bit less. But now we have taken into account, as we have said before, the indebtedness of the Company, which is indebtedness today. And we will adapt in the future these dividend ratio -- payout ratio policy.

Thank you very much.

Jean-Francois Dehecq - Sanofi Aventis - Chairman & CEO

Thank you Jean-Claude. Gerard?

Gerard Le Fur - Sanofi Aventis - Senior EVP Science & Medical Affairs

Good morning or good afternoon everybody. First slide. We have 128 products under development. In fact, we have 48 products in phase II and III, and 80 products in pre-clinical or in phase I.

Maybe even more important, we've 35 compounds in phase IIb and III, 50% in phase IIb, and 50% in phase III. In other words, we have 77 compounds in clinical trials in human, which might be a record for the pharmaceutical industry.

If we talk -- if we have a more qualitative approach, we have quite a lot of first-in-class compounds, in the CNS, in metabolic disorders or in internal medicine. That is to say that certainly Sanofi Aventis R&D portfolio is unique inside pharmaceutical companies.

Next slide, if you don't mind we'll go through each domain. And we start with cardiovascular area. In the cardiovascular area we have 6 compounds in phase II and III. And it's well known that because of Aprovel and ramipril we have a lot of knowledge in the hypertension or in the CHF domain.

We are still working in this area. We also work quite a lot on angina or on coronary arterial disease. We also work on PAD, either by chemical agent or by gene therapy, which is the case of XRP0038. In fact, talking a little bit about this compound, because we have the results of this phase IIb before the end of this year. And you will see that as a function of time(ph), they often will mention that we will have new results of phase IIb or phase III before the end of this year.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

But in fact, we mainly focus on arrhythmia. It's well known that the best anti-arrhythmic agent is certainly amiodarone(ph). However, it's also well known that this compound has quite a lot of side effects. We are very easy to criticize this compound since it is a Sanofi Aventis compound.

In other words, we have 1 of the targets of a potential anti-arrhythmic agent that we are looking for is the following, an amiodarone compound with a very safe ratio with less side effects. And this is the case of dronedarone, which is currently, as you know, by the end of February, and I can tell you that we will file this compound the second quarter of this year, both in the States and in Europe. And then roughly at the same time we will start a new safety study in patients with atrial fibrillation.

Following this compound -- and I give you more details of a very recent study -- very recent and pivotal study that we did with dronedarone in a couple of minutes.

Following this compound we have in phase IIb another anti-arrhythmic agent which is currently, as I have mentioned to you, at the beginning of phase IIb. The difference between dronedarone and this compound being that the second compound is actually once a day, although we administer dronedarone twice a day.

We have also another target in the area of arrhythmia, which is atrial rapid potassium channels. And these potassium channels are only present in the atrium, which leads to the fact that such compounds exist in animals, also in humans, devoided of any pro-arrhythmic activity or any [toxic points]. So in other words, we believe that we don't have too many competitors in this area. And that someday we will have certainly a compound that will launch in this area.

Next slide. Let's got to thrombosis. In this area we have 4 compounds in phase II and III. And as you know, we are worldwide leader because of Plavix and Lovenox. And as Hanspeter mentioned to you, we will have very new results very quickly at the ACC following a chronic treatment with Plavix with CLARITY and COMMIT plus MI.

In this area, as you know, we are leader with synthetic oligosaccharides. And this is certainly the case of idraparinux. And I will comment a little bit the third phase study of this compound in a couple of minutes. This compound is a once-a-week compound for DVTP and atrial fibrillation. And we compare this compound to vitamin K antagonist.

We have also other compounds from the same chemical series in phase IIb. This is the so-called hexadecasaccharide, which opposite to idraparinux, which is a pure tenet(ph) antagonist, this compound, the hexadecasaccharide, is a [two tenet] antagonist. In other words, it's a kind of clone of eparin(ph), but totally synthetic. And we already started the phase IIb with this compound in the prevention of cardiovascular events in acute coronary syndrome.

We have quite(ph) other compound from the oligosaccharide chemical series in development, both in phase I and pre-clinical.

Octaparine is an ultra-low molecular weight eparine, which is certainly, or possibly the back-up of Lovenox. And we will see what will be the plus of such a compound on comparison to Lovenox. It certainly, or it should be, safety.

Following these 2 big families, we also have compounds which are totally synthetic and which are selectively acting either on factor Xa, by IV routes, like automaxibant(ph) or with other analogs which are active by other routes. Automaxibant is active only with IV routes.

And we have also a non-key(ph) direct combine inhibitor, which is currently in phase IIa. In other words, a compound with the same mechanism of exonta(ph) but which is, as you know, very, very safe. So here is the compound we have in thrombosis.

In the next slide you will see the compounds in the CNS area. We had 12 compounds in phase II or III in this area. Talking about sleep disorders, as Hanspeter mentioned to you, we do hope to get the NDA of Zolpidem MR the second quarter of this year.

However, we have 2 other compounds which are currently in phase IIb, eplivanserin and the M100907, which are no more a sleep inducer, but which are compounds that increase slow wave sleep, and might have a qualitative approach for sleep disorders. All the patients of the phase IIb with eplivanserin are recruited, meaning that we will have the results of this phase IIb before the end of this year.

We roughly completed -- not yet, but roughly completed the phase IIb study with the other compound. In other words, we also have the results of the M100907 before the end of this year for the sleep disorders.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

A few words about neurology. Rilutek is still the only compound which is active in amyotrophic lateral sclerosis, but we do have a compound in phase III in multiple sclerosis, such as teriflunomide, and 1 compound in phase III for Alzheimer's disease that is xaliproden.

Teriflunomide is an amino modulating agent, which has drawn some activity in multiple sclerosis by other routes, either 7 milligram once a day or 14 milligram once a day, by using -- it's very active. We were able to demonstrate some activity by using MRI(ph). And this compound was very potent. And this is also true for physical disability.

We are currently at the beginning of phase III study in monotherapy with this compound, and we are discussing with the authority in order to build up such clinical trial on top of existing therapy with teriflunomide. To my knowledge, with an acceptable safety profile, teriflunomide is the most advanced compound which might be active by other routes for multiple sclerosis.

Talking about Alzheimer's disease. Xaliproden is in phase III. This compound is a neuroprotective agent. It is a kind of quantitative approach. This is a modifying agent, which offsets nil productive activity and induced [neural] growth.

We have 2 very large phase III studies. 1 in Europe and 1 in the States. With each we need to answer(ph) 1200 patients for 18 months. And right now we are, including both sides of the Atlantic Ocean, 1000 patients, meaning that we do want to finish the recruitment of the phase III study with this compound before summer. With 18 months follow-up, that means that we will have the results of these studies by the beginning of 2007.

We have another compound which is in phase IIb for Alzheimer's disease and for Parkinson's disease, with roughly the same mechanism of action. This is SR57667. This compound we also have recruited all of the patients for both the study in Alzheimer's disease and the study in Parkinson's disease, meaning that we will have the results of some of these studies before the end of the year. So 1 more time, before the end of the year, we will have the results of phase IIb study with this compound.

We have another compound in Alzheimer's disease which is currently in phase IIb. This is a 5-HT4 partial agonist, which is both a neuroprotective agent and also an agent which can enhance memory. So that is why we only have 3 months follow-up with this compound versus placebo. 1 more time,

we recruited all the patients of this phase IIb, meaning that we will have the results of this study before the end of this year.

1 more compound in phase IIb is the nicotinic partial agonist, the SSR591813. 1 more time, this compound is a competitor of the compound which is currently in phase III with Pfizer for smoking cessation. We recruited all the patients of the study. That is to say that we will have the results of this phase IIb study in smoking cessation before the end of this year.

A few words about psychiatric. We have 2 compounds in phase III in depression. The first 1 is the beta 3 agonist, SR58611. We already recruited the patients of the 2 phase III studies, meaning, 1 more time, that we will have the results of these 2 phase III studies before the end of the year with this compound.

With saredutant, which is an NK2 receptor antagonist, we are just starting the phase III study with this compound both in Europe and the United States.

I also just would like to add that in phase IIb we have another compound, osanetant, in schizophrenia, which is, as I mentioned to you, in phase IIb. This is the compound that was active in the so-called mega-trials in schizophrenic patients with [hallucinative] symptoms. And this compound was very active on hallucinations in this clinical trial. So we try to reproduce it in phase IIb. We recruited all the patients and, 1 more time, we will have the results of this phase IIb before the end of this year.

In other words, in the CNS area, we will have quite a lot of results before the end of this year. And most of these compounds are [indiscernible], either in neurology or in psychiatrics.

In the next slide you will see what we have in the early phase. I will not comment too much, except that as you can see we have quite a lot of compounds in phase I and at the pre-clinical level. Again, 1 more time, some of them being [indiscernible].

Let's got to oncology. In oncology here we have 7 compounds which are currently in phase II and III. And I just would like to remind you, as Hanspeter mentioned to you, that we are leader following Eloxatin and Taxotere. And I just would like to remind you that in the last 6 months we got an extraordinary [new flow] with both compounds, especially for breast and prostate cancer with Taxotere. And also, for

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

sure, for colon cancer with oncology as an additional treatment of a new formulation that we got very recently.

Following these compounds, it's well known that the main side effect of Eloxatin is neuropathy. And we are currently in phase III with xallproden in order to see whether xallproden is able to antagonize the oxaliplatin in this neuropathy. For sure it will spare the patient for the side effects, but even possibly for the potency of the compound.

1 more time, we recruited all the patients in this phase III study, meaning that we will know before the end of this year whether xallproden is able to protect patients versus the main side effects of oxaliplatin. That is to say, neuropathy. It is also, in other words, a truer concept study for the neuroprotective activity of xallproden.

We also have tirapazamine in phase III for head and neck cancer. And it's well known that this compound has a unique mechanism of action because it is more -- it's well known that its mechanism is atypical. It is more potent in hereditary conditions, that is to say that it will strongly potentiate, we do [participate] in animal, as it was the case in phase II, radiotherapy in the head and neck cancer. We do hope to have the results of this phase II study in 2006.

We also, as I mentioned to you, have 2 very atypical compounds in phase IIb. 1 for prostate cancer and 1 for small cell lung cancer. We all know that there are roughly no drugs for small cell lung cancer. Both compounds are, as I say, unique mechanisms of action. We all hope that it will be effective, but in any case, it's really a very new approach.

Just to 1 more comment on the oncology domain. We have 2 new taxoids. 1 which in phase III. And this compound has a unique profile. This compound is very active in patients which are registered to Taxotere. And with a safer profile, especially on retention of fluid and [indiscernible]. It is evident that we will have another very good profile with the compound and its analog, which is currently in phase IIa, also in breast cancer. But we have less results on this compound than the previous 1. Be sure that we will do our best in order to speed up the phase III study of this new taxoid.

You see that we have quite a lot of other compounds at the pre-clinical and in phase I level. I just would like to say that we strongly believe that with these compounds, which are rather classical oncologic agents, like Eloxatin and Taxotere.

And with a compound that we have in early stage, such as the compound which are working on angiogenesis or the compound that we share with Generum(ph), that we strongly believe that in the next 10 years the future of the oncology treatment will be the association of classical oncologic compounds, such as Eloxatin or Taxotere, in association with targeted compounds. And you recently saw very good results, for instance, of the association of Eloxatin plus [Avacine] in colon cancer. 1 more time, very good position in the domain of oncology.

In the next slide, we show to you what we are currently doing in metabolic disorders. In this area we have 4 compounds in phase II and III. It is well known that following Lantus and Apidra, the Company has a strong knowledge in the diabetes. As you know, we are still discussing with our colleagues from Pfizer in order to see what we will do with Exubera, which is currently in phase III.

But I will present to you a new approach, the compound whose code name is AVE0010, which is a GLP1 agonist, which is a new approach for diabetic patients. And again, I present to you a few results in a couple of minutes. And that you saw that in phase I or pre-clinical, we have also new mechanism of action of compounds for diabetes.

However, it remains bottom line that we are and will be leader in the area of the CB1, of the [indiscernible] receptor antagonist. For sure, that with rimonabant, and I just remind you that we will file rimonabant the second quarter of this year, I will give you some results in the couple of minutes.

Roughly all pharmaceutical industry is not working in this area. But I can tell you that the most advanced compound which is currently in development following rimonabant is, in fact, its backup. The SR147778, which is currently in phase IIb in obesity. And 1 more time -- 1 more time, we will have the results of the phase IIb with this compound before the end of this year.

We also, as you can see, in phase I, another compound which is currently in phase I with mechanism of action of blockade of CB1 receptors.

So, that is all for metabolic disorders. In the next slide, we show to you what we have in internal medicine. We have 7 compounds in phase II and III in this area. I just remind you that we got, in association with our friend from Altana, an approvable letter for Alvesco for asthma. And we are currently

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

performing the study that we need in order to answer the question of the authority.

But as everybody knows, in fact the market is more the association of corticoid with beta 2 agonist. And this corresponds to the phase IIb compound that we have, where we associated the ciclesonide to formoterol. And we are currently starting the phase IIb study with this compound.

We file fumagillin for intestinal microsporidiosis. And I will give you some results in a couple of minutes. We file this compound in Europe. And we are quite pleased to also file and develop a compound in niche market. We are here to develop blockbuster, a potential blockbuster like rimonabant. But we are also here to help the patient even if it is a niche market.

We have, with SR121463, an aqualitic(ph) agent active by other routes, and which is currently in phase III for hyponatremia, and in phase IIb for cirrhotic ascites. We finished recruitment of the patients in ascites in phase IIb. And we plan to finish by this summer for the phase III study in hyponatremia, meaning that we do hope to have the results with this compound, 1 more time, before the end of this year.

Following that, we work a lot on, let's say, inflammation, either in the gastrointestinal tract, which corresponds to ulcerative colitis, or in the lung, which corresponds to asthma or to rheumatoid arthritis, hence the wave(ph) after the CNS wave will be the 1 for internal medicine.

Next slide. A few words about vaccines. We have 8 vaccines in phase II and III. I just would like to insist a lot on Menactra. As you know, we got the license of Menactra for patients for 11 -- above 11 years old very recently. And this will be a huge success, no doubt about that, following the recommendation of the American Health Authority with this compound.

We file Menactra for children between 2 and 10. And we are currently in phase IIb with Menactra toddler, meaning that Menactra for the [indiscernible] will be certainly a blockbuster as a vaccine. And we are quite proud of that. I can also add that we will file Pentacel the third quarter of this year in United States.

So, in the next slide, if you don't mind, I will give you very briefly a few results. Let's start with dronedarone. You already saw the result of ADONIS and [ARABIS], showing that dronedarone was much more active than a placebo in atrial fibrillation patients, and with a very nice safety profile.

However, as you know, in the safety study with patients with CHS, we got unfortunately more deaths under dronedarone than under placebo. For that reason we decided to stop this [inaudible].

Here we present another phase III pivotal study, which corresponds to the effect of dronedarone on the control of ventricular rate. And, as you will see, in these patients it is another mechanism of action, another possibility that does occur with dronedarone. That is to say, a decrease in the ventricular rate, leading, for sure, to a productive effect for a patient that will suffer from atrial fibrillation.

However, when you induce a rate control both in basal conditions and during exercise, you might not have any impairment of exercise capacity. That is to say, on the duration of the exercise. So the main objective of the ERATO study was to follow patients with atrial fibrillation and to treat these patients either with placebo or with dronedarone. And to see what would be the rate control at rest and after physical exercise. And we have 6 month phase treatment for the safety of this compound.

In the next slide you will see that the primary end point was very easily reached, that is to say that this placebo bears no change in the ventricular rate. But a decrease of roughly 12 beats per minute under dronedarone with a [indiscernible] value, which is a huge 1.

In the next slide, you can see that we got the same profile of the ventricular rate at maximal exercise. For sure, there is the placebo. The ventricular rate increased from 90 to 100 -- more than 160 beats per minute under placebo. And no change following a 2-week treatment. But there was a dramatic decrease of the beats per minute of close to 25 beats per minute following dronedarone treatment.

Next slide. Fortunately expected this, we have low uptake on the exercise duration, either with placebo or with dronedarone treatment.

Next slide. 1 more time, in this study which is a 6-month safety study, we got roughly a very good tolerance of dronedarone. As you can see only 12 serious adverse events under placebo, and 14 under dronedarone.

Next slide. And the main side effects, as it was suggested in the previous study are, in fact, GI disorders. Diarrhea or some abdominal pain.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

Next slide. So, as I mentioned to you, we will file dronedarone second quarter of this year.

A few words about idraparinux, which is currently in phase III versus vitamin K antagonist. In the treatment and second prevention of either DVT or pulmonary embolism, this corresponds to the so-called Van Gogh treatment, we recruited all the patients in both DVT and Van Gogh PE, with a 3 to 6 month treatment. Then we have an extension of 6 months. And 1 more time, we recruited all the patients, the exception being versus placebo. Or in other words, we recruited all the patients for the Van Gogh program.

Concerning the Amadeus program, which corresponds to prevention of the thromboembolic events associated with atrial fibrillation. 1 more time, this is versus vitamin K antagonist 6-month treatment. We recruited, as you can see, 3500 patients. And we plan to finish that before the end of this year.

And, in other words, we strongly believe that if positive, for sure, we will file as expected idraparinux by the end of 2006. And I just remind you that this compound is a synthetic oligosaccharide. And that small dose of 2.5 milligram once a week administration in phase IIb was able to protect the patient versus DVT in the study we already have shown to you.

In the next slide, a few words of the glucagon-like [peptide] 1 agonist, which might correspond to a new approach for type 2 diabetes patients. This compound regulates the glucagon secretion, meaning that it induces a decrease in the hepatic glucose production. Moreover, it stimulates insulin secretion in a glucose-dependent manner, which, for sure, reduces the risk of hypoglycemia.

Moreover, this compound promotes weight loss by a delay of gastric emptying and a reduce of appetite. In animals, this compound demonstrates an increase in the beta cell mass in the pancreas, which meant a b-cell function, it's a kind of protection of the pancreatic cells. We could develop this compound with a different format.

In the next slide you can see the effect of this compound in phase I. This is postprandial glucose in a type 2 diabetic patients. And, as you can see, you have in blue the placebo as a [indiscernible] response curve, and it's active in all patients above 10 micrograms per -- 10 microgram administration once a day [indiscernible].

In the next slide we decided, in phase II, to compare roughly the once a day to the BID administration of these compounds. I will not enter into details of this study.

And in the next slide you can see that if we consider the area under care(ph) of the blood glucose levels after breakfast, we got really similar results either once a day administration or BID administration.

In the next slide, although we got some difference in the fasting glucose between once-a-day administration and BID administration, very -- with a perimeter with is very important, with [glycagon generated imoglodine] we got the same effect, either once a day or BID administration. And we are currently preparing a phase IIb study with this compound in order to set up the right regimen.

In the next slide you see the side effects that we got with this compound, which are mild and transient, most of them between being some headaches and mainly GI disorders.

In the next slide you can see here that this compound has potential advantages both versus classical insulin, including, for sure, possible opportunity of long-acting formulation at least once a week. And we are currently working in this area. And, as I mentioned to you, we might have a very profound effect on the b-cell function since in animals this compound decreased apoptosis of b-cell at a pancreatic level.

Next slide. A few words about rimonabant. First of all in the obesity area. And you can see here the classical protocol that you know, with RIO North America and RIO Europe. I just remind you that you got all the results of the 2-year follow-up of RIO North America, and that in a couple of days you will have the 2-year results of RIO Europe with this compound. And this is an understatement, we are quite confident on this.

In the next slide you can see that we decided to present to you the effect of rimonabant in the patients with morbid obesity. That is to say, with patients with BMI over 40. And it's well known that these patients are in danger. They have quite a lot of cardiovascular risk.

And you can see here, following 1 year of treatment, if we consider metabolic syndrome as a parameter, for sure, there is no significant difference between -- with the placebo of the 1-year treatment. 44% at the beginning, 39% at the end. But a very significant decrease after 1 year treatment of rimonabant. 52% to 32% of patients who suffer from

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

metabolic syndrome after 1-year treatment with 20 milligram rimonabant.

It is well known also that such patients suffer from insulin resistance. And fasting insulin is a good marker of insulin resistance. And, as you can see, after 1 year treatment of placebo, there is an increase in the [indiscernible] of fasting insulin of more than 3 microunits per MM(ph) and there is a decrease of 0.6 under rimonabant treatment. And for sure, this is very, very significant.

Next slide. This is also true with the number of patients with a weight loss of more than 5%. We roughly more than doubled the percentage of patients with a weight loss of more than 5%. Less than 20% of the placebo group. 47% ITT population in the rimonabant group. And what is true in the ITT population, for sure, is also true with the completers population, a double of the number of patients with a decrease in weight loss of more than 5%.

Next slide. The results are even more spectacular, with -- if we measure the number of patients with a weight loss of more than 10%, we more than tripled the number of patients with a weight loss of more than 10% after a 1 year treatment of Acomplia in these severe patients. I just remind you that these patients are very unsensitive to treatment. And this is close to 8% under placebo, to close to 26% in ITT population, and close to 40% in the completers population. Very huge risks.

Next slide. If we compare all the patients at the very beginning with a BMI screening of over 40, which is by definition, the increasing criteria. After 1 year of treatment, only 17% in the placebo group have a BMI of less than 40. It is 38% in the rimonabant group. So 1 more time, a very, very significant effect if we consider that kind of cut of at -- with a BMI of over 40.

In the next slide you will see the effect of this compound versus placebo on the weight. And you can see close to 11 kilograms after 1 year treatment under 20 milligram of rimonabant, and roughly 10 centimeter decrease in waist.

Next slide. As expected, we got a very dramatic increase in, let's say, the good cholesterol, an increase in HDL, which is very, very significant. For sure, as expected, no effect on LGL levels. And a dramatic decrease on the triglycerides level. 1 more time, as it was the case with the other patients, 50% of the effect either on the HDL cholesterol or in the fasting

insulin is linked to the decrease in body weight. But 50% is independent of the decrease in body weight.

In the next slide you will see the side effects of this compound, which is classical and well known. You can see, for instance, that patients permanently discontinued due to adverse events, 9% roughly in both cases.

In the next slide you will see that, as expected, we have [indiscernible] these others, and had very mild and transient CNS effects, as it was the case in the previous studies.

In the next slide we present to you right now the 2 studies we have with rimonabant in smoking cessation first, and maintenance of smoking cessation afterwards. We presented to you the so-called STRATUS-US, which has the same protocols as this study. And in the next slide you can see that we got a very, very significant effect of Acomplia versus placebo in STRATUS-US with an odds ratio of about 2.

And in STRATUS Europe, as you can see, Acomplia, and it is, of course, the same, was more potent than placebo, also although it didn't reach significant. But keep in mind that the odds ratio is in fact of 1.4, which is I would say not too bad. And for sure, if we pool the 2 studies, it is very, very significant, with an odds ratio between 1.7 and 1.8.

This not significant effect of the prolonged optimum is a little bit curious, but is linked to a very high(ph) classical response. It's only curious since -- next slide, we got roughly the same results on the other parameters that we got in STRATUS-US. That is to say, an increase in body weight of about 1 kilogram in ITT population under placebo, and a decrease of 0.5 kilogram under rimonabant. This is for the ITT population. And in the known obese patients with prolonged abstinence, and increase in body weight of 2.3 kilograms under placebo, and only 0.5 kilograms after 1 year, after 20 milligram treatment of rimonabant. Both parameters being, for sure, very significant.

In the next slide you can see, 1 more time, the side effects of the compound. Serious events is at 2.7 and the placebo 2.2. And complete drop-outs 6.9 under placebo, 14.6 under rimonabant.

In the next slide, as expected, 1 more time, the side effects are always the same. Mild and transient CNS effects and also some GI disorders.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

Next slide. In conclusion, even if we got high placebo response in STRATUS Europe, which leads to a non-statistic significance of the effect of 20 milligram of rimonabant, the trend was very, very positive. And we got a positive effect on the secondary end point, which is body weight in these patients.

The safety profile is similar to what we got previously. And this is also true with vital signs, blood test, ECG no effect, and on HAD CNS scales, no effect on the [indiscernible] under placebo.

Next slide. The most difficult clinical trial in smoking cessation is the maintenance of abstinence. And here I will present to you the results we got in the so-called, what we call, STRATUS Worldwide in maintenance of abstinence.

The patient receives either rimonabant 20 milligram or rimonabant 5 milligrams. And the responders were re-randomized. In the 5 milligram group there is either, 1 more time, placebo or 5 milligram treatment. In the 20 milligram group, they receive either placebo or 5 milligram rimonabant or 20 milligram rimonabant. I will present to you only the results with the 20 milligram arm, because we got no difference versus placebo in the 5 milligram arm.

On the next slide you can see here that -- you will see on the maintenance of abstinence ITT population, a very significant effect of both 5 milligram and 20 milligram versus placebo. For the non-relapse, 32% in placebo group, 42% in the rimonabant group. To my knowledge, this is the first time that the compound is active after 1 year treatment for the maintenance of abstinence for nicotine dependency. The other total(ph) I know, the compound was active after 6 month treatment but not active after 1 year treatment. And as you can see here, the odds ratio of the effect of this compound is 1.5.

In the next slide you see the effect of rimonabant on body weight. I would say, surprisingly, 5 milligram was as active as 20 milligram for the maintenance of the smoking -- of the abstinence. However, 5 milligrams bears no difference versus placebo on the body weight, although it was very significant in the 20 milligram group.

This is also true for the fasting HDL cholesterol. A very significant increase induced by 20 milligram of rimonabant. No significant increase by 5 milligrams. We don't have the data right now for triglycerides. But, believe me, there was a significant decrease of the level of triglycerides induced by 20 milligrams of rimonabant. So 1 more time, it illustrates that

fact that the effect of rimonabant on lipid parameters is not totally linked with decrease in body weight, but only partially.

In the next slide, you have here the safety in this study. As you can see, the serious adverse events 5% in the placebo group, 5.3% in the 20 milligram Acomplia group. Drop-out 6.1% in the placebo group, 9.7% in the rimonabant 20 milligrams.

In the next slide you see, in fact, that 1 more time we are -- the side effects we got are always the same. Some minor mild and transient CNS effects and some GI disorders.

In the next slide, in conclusion you can see that both 5 and 20 milligram continue to show efficacy in the maintenance of abstinence after smoking cessation. But only 20 milligrams was active on the reduction of the weight gain, and this is also true for HDL cholesterol and triglycerides in the ITT populations.

The safety is, 1 more time, very good, and consistent with all we got in all the RIO program. And for sure, no other side effects reported either for lab tests or ECG analysis.

Next slide. Following the potential blockbuster, rimonabant, just to remind you that we will file this compound second quarter of this year. We will also file fumagillin in Europe, in fact, in France, following the MRP solution for intestinal microsporidiosis, even if it is a niche market. We are very happy and proud to say that we are here for the patients.

And we are quite happy to have potential blockbusters, but also quite happy to help patients who suffer a lot, as it is the case with these kind of infective disorders which occur in patients with -- immunocompromised patient, such as an HIV patients. And it causes chronic diarrhea and malabsorption and weight loss, leading to massive cachexia. Here, fumagillin is, to my knowledge, the only active compound versus the microsporidiosis.

On the next slide you will see the effect on the parasitological clearance. And you can see it is really a very profound effect since it's a totally clearance. No effect on placebo. 100% decrease under fumagillin.

On the next slide you can see the big(ph) xylosemia is a marker of malabsorption. And as you can see, it's a very profound effect following fumagillin. And Karnofsky score corresponds to the clinical state of the patient. And we got,

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

1 more time, a very nice and important improvement of the effect of this compound.

In the next slide you will see the submissions expected in 2005. As you can see, mainly a filing of rimonabant and dronedarone second quarter this year. And in the last slide you can see all the filings with Plavix, Taxotere and zolpidem in Europe. And don't forget, Pentacel, that is pentavalent pediatric vaccine, that will file in the U.S. the third quarter of this year.

So in conclusion I just would like to say that we had, let's say, a lot of fun, a lot of pleasure to build up this portfolio. But right now the Company is ready to fight for all these compounds and that it was certainly the best deal for us to build a new team. Be sure that everybody is very passionate and devoted to the development of all these compounds.

Thank you.

Jean-Francois Dehecq - Sanofi Aventis - Chairman & CEO

Thank you Gerard. I will try to be very short in terms of conclusion to give you the opportunity to ask questions. We spend a lot of time on research and development. But I think that we have always to remember that it's our job to make and to build new innovative drugs.

I think that we want to be sure, and we are sure now after this long research and long organization of research, that with 128 molecules in development, of which 48 are in late stage of development, we have certainly a very rich and good portfolio in this industry.

What is interesting is to see -- I'm just looking, I put the figures because I think it's important. Before the end of the year, in the next 10 months, what said Gerard during his presentation is that results for phase IIb or III, and you know the results of phase IIb or III are very important in this industry, we have about 10 results in the next 10 months. So we are not only dreaming about research. We are, as you say, and as you know, always on the mark.

These products are really in major therapeutic areas. I think that we can say that all these molecules are very innovative and nothing is a [indiscernible] product. And that is a good way for the future. You saw all what we say in the past about central nervous system, and you have seen how that, in terms of this to be able to have a suite of products are arriving.

I said that 5 years ago that the most important part of our portfolio was in my mind what we have in central nervous system and at that moment, that [indiscernible] in phase I. Now we are arriving to phases II and III. That's very important. What said Gerard about oncology or inflammation is very important as the next wave for the future. And I believe that also in terms of vaccines we have a certain number of good opportunities.

What is important is the [data for less] than 6 months. Sanofi Aventis research now is fully operational, with a clear portfolio and clear objective. I think it's very important and no so quickly expected some months ago.

What were our commitments at the launch of this version in January 26, 2004? What we said. We said that we need a strong, sustainable and profitable growth. Taking each of these commitments, if you look at the strong growth it's clear that '04 in the new Group was above the pharmaceutical market. Clearly Hanspeter showed you the figures.

I think that what is clear is that the story of more products with more markets is something very, very important, very important for the future. And we will see that it's a solid basis and very important for the growth [out there].

To be clear and also to be sure that all the appropriate means are in place to push -- to push the top products. And you saw that for the 15 first products, last year we were at a gross of around 17%, [a little more than 13%]. And no reason not to continue this trend for '05.

So what we see for '05 in terms of sales is that the trend above -- clearly above the market growth -- the growth of the market will be our target. And we expect to be the result. So no reason, and it could be said that the beginning of the year is running well.

After, we say that it is not enough to have a strong growth. We need to have a sustainable growth for the future. It's easy to make good results for the next quarter or for the next year. But to prepare the future and to be sure that you have a sustainable Company, that needs a certain number of investments.

The first 1 is in R&D. And we told you in the past that it's a key, true, for mid and long term. And what we see for '05. It's clear that we are not ready to cut the research because if you see the portfolio we have in our hands, it's clear that what we have to do is to work, to invest more in clinical prize, in clinical

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

development in '05 to accelerate the development of the products. That is what will be -- that is what we will do in the next year, in this year '05. We will increase strongly our expenses in clinical trials. That is necessary and that's good news. That's good news.

After, I think that we think we will [sustainable grow] in the sustainable growth to expand and mature on the local product is very important. Why? Because it's a full vision(ph). And for us we have a good [indiscernible] after the new products arriving are making, are delivering the growth. And that's what we expected. That's the figure we have for '05. And as a result why, in '05, like we started in '04, we will increase our promotional resources for, in fact, the new commercial organization. And that's what Hanspeter told you just before.

And it's clear also that if we are in a growth of around 10%, or more than 10% in place of having 4 or 5, it's not the same way to manage a company because if you need to have -- to increase your productivity in terms of manufacturing, in terms of distribution, it's clear that with a growth of 10% it's easier than with a very low growth. And for the future that's something which is also very important.

After, the third term, which is a profitable growth. I think that the '05 result that you have seen -- 18 -- a little more than 18% confirms the potential of our Company, our new Company. We have met and will reach our synergy target. That's clear. I know that you want always that we give more details inside the synergies that we need to see to know how many people will be fired, how many plants will be closed and so forth, I think it's not a good solution.

And not only yet, it's first because I think that it's normal to start a discussion with the people to be sure that the people are properly motivated and running and not sitting. I think that we need to first discuss this kind of question with the people, with the salaries of the Company.

But what we can say also is that it depends on the results of our growth because we are trying to push the top line of our P&L. And I think that's the best way to have good results and good future. And we have to adapt the story at what will be the growth.

Remember when we merged Sanofi and Synthelabo, we have very beautiful clarification of the synergies, how many people we have fire, and so forth. And I remember, for example, that

we put for the second year 1500 people to fire and at the end of the year in place of firing 1500 we hired 500 people.

What I can say, yes, 1.6b is our commitment. It will be done, clearly. At the end of '04, in place of making just a 10% of our synergies at 160m, we have 220m, despite the fact that we started only in August. It's very important because if we are at this level in '04, you can be sure that '05 will be met without any big problems.

220m, that's certainly the most important -- the most important part is in general expenses, because the first fact is the structure. Up to now you are closing 1 headquarter or 2 in each country, when we are taking only 1 headquarter in place -- I corporate headquarter in place of 5. This [means that we will have] this kind of synergy very quickly.

After, you know that a certain number of decisions taken in '04 will have the results in '05. And I can tell you that some 1,000 people, it was around 3,000 people last year, which leave the Company or were not hired. It will mean the same level but more this year. But in the same moment, if we want to succeed in our story of pushing the [indiscernible] that we are not ready to cut the people, in the fact that we are not ready to put a lot of people in the sales force. In place of that we will have to hire people.

But we have very important cost cutting in terms of cost shaving(ph), in terms of many contracts, contracts in research and milestones on research and so on and so forth. So I think be confident that the 960m which are our commitment for '05 will be done without any big problems. And we will manage the story. And especially the story, to be sure, of the motivation of the people. And to keep this very strong motivation, which is the most important results of ours after 6 months.

What will be our objective for '05? If we said that in terms of earnings per share, we will have the same at the level of 1.25 for euro/dollar. It's important to say that. But I think that yes, our target is to be at the same level of growth in '05 than in '04. So that is to say that we will be around 18%. If we can do more, we will do more. But our commitment is 18%.

And it's very important, because it's after a strong increase of our investment in data research, but also with hundred, many hundred million euros investment for the pre-launch of Acomplia. So that's our target for '05. It's not -- it's very important that that's clearly our commitment.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

If we look at '05, what we would say. In January, 1 year ago, we said that we need a very rapid integration. For that reason that we take the way of meeting something which is more [indiscernible] than amical(ph) takeover. It's very important. And we said 1 year ago it's important because the story of the pharmaceutical industry could change dramatically in the next years.

I think that looking at the last 12 months, I think that yes, the pharmaceutical industry changed dramatically. And I think it's a big success, I would say, in this so rapid integration to have a fully operational Group at the beginning of '05. And that's only the success of all the people inside the Company and the motivation of all the people at all the levels of the Company. And that's certainly our best success for the future.

So, after I continue to tell you that our commitments of 1 year ago for a strong sustainable and profitable growth will be met in '05, like in the next years. Thank you very much.

So now we go to the questions. Now we proceed.

QUESTIONS AND ANSWERS

Operator

[OPERATOR INSTRUCTIONS]. And we will take our first question from Paul Major with Redburn. Please go ahead sir.

Paul Major - Redburn - Analyst

Thank you. Just a couple of financial questions. Just looking at the French GAAP consolidated numbers, with 15b of sales. We know what the H1 sales for Sanofi alone were. We know what the combined proforma sales were for Q4. The implied number for Q3, as a percentage of the proforma number looks a little bit low. I was just wondering if you could tell us if there were any effects on sales in that quarter.

With regards to the 220m of synergies that you've mentioned, could you tell us if that is an actually achieved number since August 20, or an annualized total for 2004?

And with regards to your guidance for EPS growth for next year, what are you assuming with regards to income from equity associates during 2005?

And then finally, could you give us some guidance on capital expenditure in the next couple of years? Thanks.

Jean-Francois Dehecq - Sanofi Aventis - Chairman & CEO

I think that we are no good return and please ask very short questions to be sure that it can be understood here. Jean-Claude, you understand the questions?

Jean-Claude Leroy - Sanofi Aventis - SVP & CEO

Not all of them unfortunately. As far as the question on the synergy, which were realized in 2004, the question was were they annualized or were they realized as of the acquisition date, meaning as of August 20. Obviously they were annualized in 2004 as compared to 2003.

The French GAAP, I didn't get the question properly. There was too much return on the speakers. So could you ask again the question on --?

Paul Major - Redburn - Analyst

Sure. I was just looking at the Q3 sales implied by the French GAAP reported number, given your prior H1 sales and what you're reported for Q4. And the number just seems is a little bit lower than I would have expected. So I was just wondering if there were any effects in the third quarter on the sales.

Jean-Claude Leroy - Sanofi Aventis - SVP & CEO

There were not actually. As you know, the sales that were reported by the new Group began actually August 20, meaning by that, let's say, 4 months in '04. Now there were no major change or disadvantage of change in methodology in between the first half and Q3 and Q4. So no, I don't see no particular reason for a change between the last 2 quarters.

Paul Major - Redburn - Analyst

Thanks. And then the final 2 things were guidance on associate income and CapEx for the next couple of years. Thanks.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

Jean-Claude Leroy - Sanofi Aventis - SVP & CEO

[I am sure] you are best to give the detail. No, the only thing I can say when I made a comment about the associate income is that the amount that was showed in the 2004 P&L was more reasonable than the heavy charge we saw in the 2003 P&L. I guess that for the rest we won't enter into the various details of all the line items of the P&L.

Operator

Thank you. We will now take a question from Jo Walton with Lehman Brothers.

Jo Walton - Lehman Brothers - Analyst

Good afternoon. A few questions please. Could you tell us how representative you feel the 5.5b of cash flow from operations was going forwards? Your actual level of disclosure of the cash flow at this stage is obviously very limited.

Secondly, I wonder if you could identify the line items where we should see the benefits of the synergies coming through. Unless you're expecting 18% top line growth as well as bottom line growth, there will presumably be some margin improvement. But you have talked about a higher level of R&D. Do we expect to see the synergies showing in a reduction of the SG&A as a percentage of sales or the cost of goods or both?

And finally, could you give us some idea of the ongoing restructuring charges? You have excluded the restructuring charges from the merger from your earnings. But presumably in order to get these savings going forwards you will have to ultimately spend more than 500m. Where will that be booked? And is that part of the ongoing income?

And just a very final question, could you tell us what the impact of foreign exchange was on your 2004 earnings? You've given us a very helpful guide as to what the impact will be in 2005.

Jean-Claude Leroy - Sanofi Aventis - SVP & CEO

Okay. Your first question was on the cash flow from operations, the 5.5b. What I can tell you is that in that, the need for working capital was showing a need actually in 2004 by around 800m. Now even though I don't give you too much of a detail for 2005, this is for sure that we are going to

utilize cash in 2005, just for the sake of spending the necessary money for the restructuring costs.

So that if, in turn, because of the guidance, you saw on the EPS line, which means more important net result -- bottom line result for the construction of the cash flow from operation the other way around. There will be more natural expend, need for working capital because of the restructuring.

You were asking second question where are we going to see the synergies in which line items in 2005. As Mr. Dehecq said, there will be several origins. And when he was talking, for example, of purchases obviously we are going to see consequences in the gross margin as well as in R&D as well as in SG&A.

Now, obviously there is 1 line item which is going to show probably the more important part of it, which is the administrative part of the SG&A. The G&A in itself. We said that we are going with monies in R&D, that we were going to support the launch of products and from a commercial perspective. And we are going to do all what we said to do as far as the headquarters are concerned. So I would suspect that a great part of it is going to show up in the SG&A.

Remember that as far as the R&D is concerned, 1 part of the synergy we have mentioned is the fact that we are not going to push [forward]. We have already stopped some contractual agreements which existed in the past between some biotech companies and Aventis. And this is part also of the synergies.

On the restructuring charge. We discounted around 560m in 2004, I am talking before taxes. Where is it? This is what you see in the consolidated accounts but it is not in the adjusted net income, just because we have said before that in this kind of charges are excluded. Next year is going to be the same.

Probably a larger charge in 2005 than we encountered in 2004. Again, not in the adjusted. But, as you mentioned before, we are going to have to spend the money accordingly and that is what is going to burden a little bit the cash flow from operation if so from a cash flow perspective.

Now, foreign exchange. It is right that we gave guidance with sensitivity to the euro/dollar priority(ph). And we said that in that respect that for 2005 a difference by 0.5% in the EPS would arise by each cent of dollar change in the priority. Now the question was more dedicated to 2004.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

Well, you know, it's been, as you know, not very easy when you talk about proforma to do a briefing. But we could give a figure on each line item of the sensitivity to the priority. We have chosen not to give too many figures on each and every line.

We know for the time being the dollar has been decreasing. So obviously this is a drawback on a year per year comparison from the time where probably, and hopefully, if the dollar is going to improve, it's going to be the other way round. And that's the reason for which we choose not to give the impact on each and every line item. Again, obviously indefinitely, this has been a drawback in the comparison between 2004 and 2003. But we are not ready to change from euro to dollar to have better figures. Too many people have done that.

Operator

Thank you. We will now take a question from Graham Parry from Merrill Lynch.

Graham Parry - Merrill Lynch - Analyst

Good afternoon. I'm just wondering if you can give us a little bit more detail on the other operating income line, especially compared to how you booked this in your F4 release in November last year. If I take the 581m you get from Bristol-Myers, less the 250m you are paying out, that leaves about 102m which could be accounted for by the income from Actonel. So could you confirm that this is the only item that contributes that 102m or are there other items contributing to this line as well?

And then a follow-on to that as well, where the other items have been booked, such as the 400m in Aventis license income as well.

Jean-Claude Leroy - Sanofi Aventis - SVP & CEO

Okay. Mainly your question is dedicated to the Actonel alliance booking. And you are right to mention that in the notes of operation, the F4, we did show up a line item of other operating income and expense [were rather billion] euro rather than what we are actually showing actually by 400m. Now what did happen?

Again, we did harmonize the presentation of the operation from the Aventis perspective to the Sanofi Aventis, meaning

the old Sanofi perspective - in that respect. What did happen to the Actonel treatment, the Actonel alliance treatment?

We did book the royalties as we do for any other, and especially for Bristol-Myers Squibb in the cost of goods. So it is a great part of the difference between that million and what we show up, which has been, I would say, setting back to the cost of goods sold, obviously, in 2003 and 2004. So it's comparable in the schedule.

Now, in addition to that, you know that, for example, we are giving some promotion -- our sales forces are promoting Actonel in the U.S. We are rebilling that to Proctor & Gamble. How did we treat that? We did treat that by subtracting what we are rebilling from the total of our sales force, exactly the same way we are doing when we are promoting Plavix and Avapro in the U.S. And you know that we are not the 1 who is driving the product, per se, in the U.S. The Plavix 1 it is BMS in that example. This is Proctor & Gamble.

So [indiscernible] over this line item, per line item, the remaining -- the balance of that is what we make -- of profit we make on the product. And this is only this part which has been booked in the other operating income and expend line item. So again, same kind of treatment in 2004 and 2003 for Actonel and Avapro and Plavix.

Now, your second question what was the original increase by 102m. Well, I can say that there are several other smaller agreements, especially in Japan on this line item. But, generally speaking, I would say close to half of the increases are coming from the alliance with Bristol-Myers Squibb, and close to 1 half of the increase of this line item is coming from the alliance with Proctor & Gamble on Actonel.

Graham Parry - Merrill Lynch - Analyst

Okay. Can I just follow up there as well? If you look at 1 of the items that contributed to that figure in the F4, it was the 400m, I think, in license income that Aventis was booking in its 2003 historic numbers. What's happened to that line item? Is that now being booked as an offset to SG&A?

Jean-Claude Leroy - Sanofi Aventis - SVP & CEO

You are right. As long as we provide services, it diminishes our charges as long as Proctor & Gamble is providing services in Europe where we do consolidate in some countries the

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

sales. It does increase our SG&A line item, facing sales and charges or no charge when there are no sales.

Graham Parry - *Merrill Lynch - Analyst*

Okay. Thanks very much.

Operator

Thank you. We will now go to Credit Suisse Asset Management to take a question from Stephen Putnam.

Stephen Putnam - *Credit Suisse Asset Management - Analyst*

I've got a nice simple 1 hopefully. In the operating income of 8163 on the adjusted basis, could you just tell me what the depreciation charge is as part of the costs? And just to confirm that the only amortization expenses that you record are the ones you have already given us - the 110m and the 9m.

Jean-Claude Leroy - *Sanofi Aventis - SVP & CEO*

Okay. Another technical 1. As I said, this is an adjusted proforma P&L. So the only amortization remaining in this P&L is the ordinary amortization of the industrial and IS investment. And roughly speaking, in 2004, we have been talking of around 750m of amortization.

Stephen Putnam - *Credit Suisse Asset Management - Analyst*

That's of the fixed asset amortization -- tangible fixed asset amortization.

Jean-Claude Leroy - *Sanofi Aventis - SVP & CEO*

And information system.

Stephen Putnam - *Credit Suisse Asset Management - Analyst*

Right. 750m. Okay. Thank you.

Operator

Thank you. We will now take a question from Michael Leacock from Nomura.

Michael Leacock - *Nomura - Analyst*

Good afternoon gentlemen. I just wondered, you started to talk quite a bit about the body mass index of 40 or more for rimonabant. And I just wondered whether perhaps this was a signal in any way of a slight change in the strategy or the indication that you're going for with that product. Perhaps you could confirm the wording of the indication that you intend to seek.

Secondly, I think you mentioned, Mr. Dehecq, that Aventis had a considerable number of projects and consultancies, particularly in R&D that you are not continuing. I wonder if you could just give us, perhaps, a total for all of those that you're not continuing. I think you said on the call this morning each of them amounted to 10s of millions. I just wondered what the total would be. Thank you.

Gerard Le Fur - *Sanofi Aventis - Senior EVP Science & Medical Affairs*

So concerning the so-called political approach of the profile of rimonabant, there is no change. This compound is not at all a cosmetic drug. It is a drug for the cardiovascular risk associated to visceral fat. And we just wanted to show to you the results we had with this type of relation morbid obesity, because morbid obesity has quite a lot of cardiovascular risk. And we just wanted to show that to you. There is no change in the strategy concerning the compound.

The only difference you will see, or the only additive that it will add, apart from the 2-year follow-up in RIO Europe, you will have in June the effect of this compound in all these patients with diabetes. That is to say that you will see in this condition how potent is the compound.

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

About the second question, I think that looking at the consequences and so forth, I think that what we are looking around the world is more than 100m, [that is]. And in plus we have to put a certain number of research contracts. But I am not ready to give you the global information today because we continue to be in discussion in a certain number of contracts. So it will be added to this more than 100m. So it's a lot of money.

FINAL TRANSCRIPT

SNY - Q4 2004 Sanofi-Aventis Earnings Conference Call

Michael Leacock - *Nomura - Analyst*

Thank you very much.

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

I think that if it's the last question I want to thank you very much for being with us for more than 2 hours. And I expect that this meeting give you the information you need.

I am sure that in terms of research and portfolio and research, you learned a number of things. In terms of sales I think that the trend that we saw during the last quarters continues to be the trend for this year.

And be sure that even if we are not ready to give you line by line and people by people the synergies, all what has to be done will be done in a very fair atmosphere inside the Company because, I repeat, what we need is to have people running and not people sitting because they are disappointed.

And the success of this merger and it's served 6 months, something which is certainly like a success. And the success is the success of all the people because we found a very fantastic motivation of all the people around the world at all the levels. So I think we have to continue at that. But be sure that all the synergies possible will be done on time and we will deliver that like our commitment.

Thank you very much.

Operator

That concludes today's presentation. Thank you for your participation. You may now disconnect.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2005, Thomson Financial. All Rights Reserved.

Exhibit G

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

CORPORATE PARTICIPANTS

Felix Lauscher

Sanofi-Aventis - Director, North American IR

Mark Cluzel

Sanofi-Aventis - SVP, Development and Scientific Affairs

Douglas Greene

Sanofi-Aventis - VP, Development and Medical Affairs

CONFERENCE CALL PARTICIPANTS

Andy Kocen

Redburn Partners - Analyst

Matthew Weston

Lehman Brothers - Analyst

Jean-Jacques Lafier

Auto Securities (ph) - Analyst

Mark Purcell

Deutsche Bank - Analyst

Michael Leacock

Nomura - Analyst

Ben Yeoh

ABN Amro - Analyst

Lucas Herrmann

Deutsche Bank - Analyst

Timothy Anderson

Prudential Equity Group - Analyst

James Terrill

Capital Research Global Investment - Analyst

Rajna Upadia

UBS - Analyst

PRESENTATION

Operator

Good day, ladies and gentlemen, and welcome to today's results on Plavix and Acomplia on the American Cardiology Congress conference call. For your information, this conference is being recorded. At this time, I would like to turn the call over to Mr. Felix Lauscher. Please go ahead.

Felix Lauscher - Sanofi-Aventis - Director, North American IR

Hello, everyone, and again, welcome to the Sanofi-Aventis conference call on the results of the COMMIT and CLARITY trials, as well as the RIO-Europe 2-year data as presented at the American College of Cardiology here in Orlando yesterday and today.

I am Felix Lauscher from the Investor Relations team at Sanofi-Aventis. Sitting here with me are Mark Cluzel, Senior Vice President, Development and Scientific Affairs at Sanofi-Aventis, and Douglas Green, Vice President, Development and Medical Affairs at Sanofi-Aventis.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Mark will begin today's call with a discussion of the results of COMMIT and CLARITY. After that, Doug will walk us through the RIO-Europe 2-year data presentation from yesterday. Following the presentation, we will open the call for Q&A.

The slides are available during the webcast on our website. Mark and Doug will refer to the relevant slide numbers and/or titles in order for you to follow their presentation. And with that, I pass it over to Mark.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Hello. Good morning or good afternoon. So I will start with the slide number 2 which is incidence of acute coronary syndrome in the U.S. The scope of the 2 presentations this morning was on myocardial infarction (ph) with ST elevation. If you're looking at the slide, you can see that in fact ST myocardial infarction is part of the global group which is called acute coronary syndrome. One of it is -- this group can be divided into unstable angina and MI. And the MI itself can be distinguished between non-ST-elevation MI or ST-elevation MI.

Unstable angina and ST-elevation MI were already studied during CURO (ph) with very positive results -- I think already with production close to 25 percent. But so far we have no result with Plavix in the early setting of myocardial infarction with ST elevation. This study was performed just -- just to give you an idea of the global population, it represents in the U.S. close to 400,000 patients.

I have also to say that the 2 studies presented today, COMMIT and CLARITY, are complementary. They are complementary on the outcomes, since CLARITY was looking to a reperfusion outcome -- so a kind of surrogate endpoint, when COMMIT was looking to twin points, which was death and morbidity from a casual clear (ph) origin. They were complementary in terms of medical habits (ph), because CLARITY was done in Europe and U.S., and COMMIT was done in China. And I think it is interesting -- in order to see that the effect of Clopidogrel are quite going on (ph) even with different background territories (ph). And they are also complementary in terms of age. The maximum age for CLARITY was 75 years old. When in COMMIT, the inclusions with the area -- there was no precision on age. And in fact, there is more than 30 percent of patients above 75 years old. And I think the oldest guy is 100 years old.

So starting with CLARITY, CLARITY is the study of the Jimmy (ph) group, so from Professor Brungard (ph) and was presented by Gasteau Sabatin (ph), which was the principal investigator. As I told before, it is a weight-efficient (ph) study.

The primary endpoint -- sorry. So now you're going to page 4. On page 4, you can see the design of the study. The primary endpoint was at angiography. It could be between 2 and 8 days. And in fact, the main treatment duration was 4 days. The primary endpoint is reperfusion. But there is also a secondary clinical endpoint -- sorry, a secondary endpoint, unclinical (ph) endpoint which is at 30 days. And you will have results of these 2 endpoints in the following slide. So, slide number -- oh, just also 1 point. This study is available on the web at the New England Journal of Medicine, because it was published this morning at 8:30 U.S. time.

So for the primary endpoint, which is slide number 5 -- for the primary endpoint, which was improvement of coronary reperfusion, there is a very good reduction at vis-a-vis (ph) and very nice improvement of reperfusion with Clopidogrel. With an out (ph) reduction of 36 percent versus placebo.

If you're going now to the slide number 6, what is very interesting is that these results in reperfusion is very current (ph), since if you're looking to all the possible subgroup -- we have not all the possible subgroup, but a large number of possible subgroups, you can see that the superiority of Clopidogrel or Plavix versus placebo is consistent for all subgroups, including age and including male and female, which sometimes is subject to discussion.

So, now, if you are going to the slide number 7, the previous endpoint was the primary endpoint -- it was the reperfusion endpoint -- a kind of surrogate endpoint for morbi-mortality. The surrogate endpoint is a true morbi-mortality endpoint. Since it is a cumulate aggregate of 30 regular (ph) days, myocardial infarction or recurrent ischemia leading likely to PCI. And here also, you can see that there is a very good results, with 20 percent of the reduction of the critical events favoring Clopidogrel. So a good consistency whatever is the subgroup, and the good consistency of the endpoint between roughly 4 days and 30 days.

Also, I think one of the very interesting parts of this disease is the safety parts. So now I am on page number 8. As you can see, there is no significant difference in terms of the bleeding, tiny minnow (ph), tiny minor (ph), or tiny major (ph) between the two compounds. Of interest is intracranial hemorrhage. And as you can see, there is absolutely no difference in intracranial hemorrhage in the Clopidogrel versus placebo in the population which has a high risk of bleeding. So it is a very reassuring event.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Also, not on this slide but presented this morning by Dr. Sabatin (ph), in patients undergoing CAVH (ph) within 5 days -- and you know that there is some -- some people are thinking that there is some of prescribing Clopidogrel prior CAVH for risk of bleeding. And at this presentations this morning, for this population, they was observing no difference in bleeding between Clopidogrel and placebo.

So now, I'm switching to the slide number 9 to COMMIT. COMMIT was a multifactorial design, and the principal -- it was leaded by the Oxford Group and Professor Peto (ph). And Dr. Chen (ph) was the principal investigator. It was a multifactorial design, including Clopidogrel and Metoprolol. I will discuss in this presentation only Clopidogrel. Just for your information, Metoprolol was not positive on the global mortality. But the discussions in morning, it was said that Metoprolol -- it is likely to be effective with an early administration in the subgroup population with no impairment of the left ventricular function. No heart failure at the beginning, because, in fact, the improvement in arrhythmia and myocardial infarction was counterbalanced by cardiogenic shock intrapopulation with impaired left function. But it's not Plavix.

So if we're going to slide number 10, you have the design of the study. So patients were randomized with an acute STEMI within 24 hours. It was 46,000 patients, or 23,000 patients in each group. It was placebo versus 75 milligrams. One difference or so interesting between CLARITY and COMMIT that in CLARITY, you had a loading dose of 300 milligrams, when in COMMIT in fact you do not have a loading dose of 75 milligrams.

The primary endpoint -- there was in fact 2 primary endpoints. One was death (ph) -- non-fatal MI or non-fatal stroke. And the other endpoint was all death (ph), which is a very difficult endpoint to reach. So now, if you're going -- the mean duration here -- the treatment was started (ph) as the charge of the hospital. And in China, the mean duration of fix utilization (ph) following STEMI is close to 15 days. So the treatment duration was 15 days, and an endpoint evaluated as the discharge from the hospital.

So now, when you are going to the slide number 11, you can see that the adjunction of Clopidogrel to already sub granitic (ph) and aspirin and sometime Metoprolol is providing relative reproduction of 9 percent. Highly significant on the composite endpoint of death, MI, or stroke by MI -- or stroke, sorry. It was -- sorry, there is a vacuum cleaner -- it has to be not that -- in fact, when you are looking at the previous result in the last decade, all compound except TTPA (ph) and aspirin failed for the composite endpoint. So it is a very robust results.

And this robust result is comforted by the slide number 12. When you are going to all mortality -- and you can see that there is reduction of the all global mortality by 7 percent, which was specifically significant. For your information, it is also the first time that we're showing a benefit of Clopidogrel for all mortality that are. And to give you an idea of how many lives can be saved by the use of Clopidogrel in this indication, it is roughly 5,000 patients for 1 million patients. So 5,000 deaths for 1 million MI, knowing that in the world you have close to 10 million MIs per year.

So now, going to slide number 13, you have to consider that we have 35 percent with patients over 75 years old, which is a very high risk population for hemorrhagic stroke. And as you all can see from the data, the number of hemorrhagic stroke between Clopidogrel and placebo is strictly identical -- 55 (ph), 50 (ph), 40 (ph). Now again, and its confirming the good result on bleeding on the 50 of Clopidogrel in bleeding in CLARITY. So CLARITY and COMMIT also for that are very consistent. You have also a reduction of ischemic stroke by Clopidogrel, but the drug is already registered for that.

Now going for other bleed or major bleed and other bleed, there is a small, but not significant, increase of bleeding with Clopidogrel for the major bleed, with 82 versus 73, and good tolerability for other bleed with Clopidogrel.

Now, going for the page number 15, in the kind of conclusion, we can say that these 2 studies demonstrated a significant improvement in coronary perfusion on clinical outcome basis on CARE (ph) and CLARITY; a significant reduction in mortality for patients with having Clopidogrel versus pan LK (ph) alone in COMMIT. And as I already stressed, no significant increase in major bleed or intracranial hemorrhage, both COMMIT and CLARITY. And also remember the CAVH that are within CLARITY.

And now, the last slide. Just to remember the relative extensive lifecycle management with the Clopidogrel involving both the (indiscernible) cardiovascular operational (indiscernible) events and we are still continuing the next -- so now, I think we have addressed most of the secondary prevention with the cardiovascular population. And the next big event will be likely next year with the result of CHARISMA, including also cardiovascular population, but in high risk populations. So some time without produce event.

And now, I pass the speech, the talk, to Doug.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Good morning, good afternoon. I have the pleasure of being able to present to you the RIO-Europe 2-year results, which were presented to the American College of Cardiology yesterday by the principal investigator, Luc Van Gaal, from University Hospital in Antwerp.

If we go to slide number 18, it's important to remember that the RIO-Europe study is part of a large Phase III program. And fundamentally, the results of RIO-Europe provide along with RIO-North America evidence in support of 2 aspects of Acomplia -- one, that the metabolic and body compositional benefits which are accrued in the first year are maintained throughout the second year and that with prolonged administration, we have a very positive tolerability profile, so that largely the RIO-Europe studies are confirmatory and consistent with what has been reported previously in the RIO-North America study.

Now I'd like to take you through some of the elements of the study. Many of you are familiar with this, so I'll try to be a little bit brief. If we go to slide number 19, this recalls that all of the patients in the RIO program were maintained on a mild hypocaloric diet, which was calculated to be a modest 600 kilocalories less than their previous diet. And they were randomized after a single-blind running period of 4 weeks to either placebo or 2 doses of Rimonabant, 5 milligrams or 20 milligrams.

The RIO-LIPIDS study was ended at week 52. The RIO-North America and the RIO-Europe studies continued the patients into a second year of observation, but with the important difference between RIO-North America and RIO-Europe. In RIO-Europe, the patients were maintained within the study arm to which they were originally randomized. In RIO-North America, patients who had been randomized to active drug, 5 or 20 milligrams, for the first year were rerandomized on a 1-to-1 basis to either continuation of drug or conversion to placebo.

And so, the 2 studies ask slightly different questions. The RIO-North America study was asking the question as to whether or not continued therapy was necessary to maintain the positive benefits. The RIO-Europe study was designed to ask the question, how potent is Acomplia in maintenance of the benefit achieved in the first year. And so the 2 studies are complementary, but with a nuance of difference.

If we go to slide number 20, the primary efficacy assessment criteria was the absolute change in body weight from baseline to 1 year. And the data that we're reporting now, which is the 2 year change from baseline, is the secondary endpoint. Other secondary endpoints were essentially equivalent to what has been done in the other RIO programs in terms of responder analysis, change in waist circumference, important changes in metabolic parameters, and the prevalence of the metabolic syndrome as assessed by the ATP3 criteria.

Slide 21 demonstrates again that the patients that were examined in the RIO program were not by and large the healthy obese, but rather, were people who had metabolic and cardiovascular risk factors as a result of their being overweight, with a prevalence of hypertension and metabolic syndrome of about 40 percent of baseline. And almost two-thirds of the patients also had a concomitant dyslipidemia of the type associated with overweight obesity and metabolic syndrome, which is low HDL and high triglycerides.

Slide number 22 shows the body weight change over the first 2 years in the completers. And you can see that the results that were obtained at week 52, which had previously been reported were essentially maintained throughout the second year. If we put this in perspective, the delta between placebo and the 20-milligram population was 4.7 kilograms at the end of 2 years. And that's essentially more than a 10-pound weight loss. And if we look at the patients who were treated with Acomplia 20 milligrams, if we include the run-in period and we look at the absolute weight loss, not the placebo-corrected, they are approaching 20 pounds of weight loss from the time that they were initially screened.

The next slide shows the intention to treat last-observation-carried-forward analysis, which demonstrates the statistical validity of the weight loss which I showed you in the previous slide. And we need to recall that in a study which is almost 2 years long, from a patient's perspective, probably the completer analysis is more relevant in terms of expectations for patients who stay on the drug. But nevertheless, we have -- again, if you take the most conservative calculation, which is the placebo subtracted LOCF, we come up with 4.3 kilograms, which again, is almost 10 pounds of body weight based on that statistical construct.

Slide 24 shows that as in previous studies that we've reported, both at 1 year and in RIO-North America at 2 years, that waist circumference, an important component of the metabolic syndrome, tracks very nicely with what is seen in the change in weight. And here, we're talking about probably patients when you compare the placebo losing 5 or 6 notches in their belt, which is I think puts it into real terms as to what a patient might actually experience.

The next slide, slide 25, shows the same statistical analysis, the conservative analysis looking at LOCF, and again, validating the strong statistical robustness of this finding and being quite consistent with what we've seen in the RIO-North America, and certainly at 1 year, consistent with what is seen in the RIO program in general.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

We -- as you well know, responder analysis is -- has great importance in terms of physicians' experience and patients' experience. And we see that at 2 years, the responder rate here is reflecting a 10 percent weight loss, which would translate into roughly 22 or so pounds -- essentially, remains consistent between the 1-year and 2-year results, again, suggesting the sustainability of the improvements which are seen in body composition.

But I would hasten to add that Rimonabant is not a drug primarily focused on body composition, where we believe the importance of Rimonabant is in its ability to influence the cardiovascular risk that is associated with metabolic syndromes. And I think the results that I'm going to show you in the next few slides speak to the strong evidence of sustained benefit in terms of what we think is probably the most important benefit of Acomplia on cardiovascular risk profile.

So on slide 27, we can see -- looking at HDL, the very nice increase in HDL which was reported for the first 52 weeks is essentially maintained in a very consistent pattern over the succeeding 52 weeks up until 2 years. And on slide 28, we see that exactly the same pattern in terms of triglyceride lowering with a placebo subtracted difference of about a 15 percent lowering of serum triglyceride. In the completer population, the LOCF data as shown below is a 10 percent reduction in serum triglyceride.

And importantly, as we had demonstrated previously at 1 year, these benefits reflect not only the improvements in body weight and waist circumference, but importantly, the multipronged mechanism of action of Acomplia, which has a number of beneficial effects on metabolic parameters of cardiovascular risk. And we confirm at 2 years, as we reported at the end of 1 year, that about half of the beneficial effects on lipid parameters were a function of the pharmacologic action of Acomplia, and were above and beyond that which would be anticipated from the degree of weight loss alone, which we think is an important differentiating finding for Acomplia.

If we go to slide number 30, we see that the beneficial effects in terms of insulin sensitivity, correcting the insulin resistance, which is so much a reflection of intra-abdominal adiposity -- that the reduction in fasting insulin, which was reported at 52 weeks shown in the left panel, is maintained throughout the 2-year study period, and that the assessment of insulin resistance by the HOMA insulin resistance parameter shows that once again, there was a reduction in that parameter at 2 years with 20 milligrams of Rimonabant, whereas the placebo group actually showed a deterioration over that period of time.

I think importantly, we all know the importance of metabolic syndrome as a major, if not at this current time perhaps the major, metabolic cardiovascular risk parameter in the developed countries. And certainly, the combination of the improvements in waist circumference, HDL, triglyceride, and improvements in insulin resistance would be expected to translate into a beneficial effect on the prevalence of metabolic syndrome. We had reported that at the end of 1 year, the prevalence of metabolic syndrome had been reduced by more than half in the subjects that were treated with 20 milligrams of Rimonabant. And what you can see in slide 31 is that this reduction -- this reversal, if you will, of the metabolic syndrome, seems to be a long-lived benefit of Rimonabant, and certainly persists up to 2 years without any evidence of loss of that benefit.

We're all concerned about the benefit/risk calculation. And if we look now at slide 32, we find that the positive tolerability data which we have accrued in previously reported studies is maintained in the RIO-Europe study, extending up to 2 years. Subjects with any adverse events of about 85 percent were expected in a trial of this nature. That extends for 2 years. There was no difference among the 3 treatment groups in terms of adverse events. Serious adverse events -- again, consistent among the 3 treatment groups; the deaths occurred, which you would expect in a population like this in a study of the size and duration were distributed among all 3 treatment groups. And as we have seen before, there is a slightly increase in the discontinuation rate due to adverse events in the 20-milligram group compared to placebo consistent with those figures that have been presented before.

But the most important aspect of that component is shown on the next slide, which looks at when subjects were discontinuing due to adverse events in the 3 groups. The top line is a repetition of the last line on the previous slide, showing once again that there was a slightly increase in the frequency of discontinuation due to adverse events in the 20-milligram group compared to the 5 and the placebo.

But if we look down at the next 2 lines and we break that down by year, we find that the excess discontinuation rate in the 20-milligram group all occurred within the first year. And in fact, if you look back at the data, they all occurred within the first few months of entry into the double-blind period of the study, reinforcing the notion that the adverse events which are seen with Acomplia tend to occur early in treatment. Many of them are mild and transient. And those which lead to discontinuation do so in the early parts of treatment, and that in fact, once you look at year 2, the discontinuation rates for adverse events were essentially the same among all 3 treatment arms. This is exactly what we have previously reported with RIO-North America. And so once again, the RIO-Europe study has not only confirmed the RIO-North America findings in terms of efficacy, but also the very positive results for tolerability, as well.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Just going to the next slide, which is slide 34 – if we look at the adverse events leading to discontinuation, again, consistent with what we have previously demonstrated, there is a slight increase in discontinuation due to depressive disorders, but not to lutoalteration (ph). And there is an increase in discontinuations due to nausea, vomiting, and as we have previously reported. So once again, the distribution of adverse events confirm what we have previously disclosed.

Slide 35, again, demonstrates the cardiovascular safety, looking at blood pressure, heart rate, and QTC, once again confirming the very good profile for cardiovascular safety that we've reported in our previous Phase III trials.

And so going to slide number 36, we can conclude that the robust data has now been replicated in 3 1-year and 2 2-year study, demonstrating that Rimonabant produces significant reductions and maintenance in waist circumference and weight improvements; significant improvements in metabolic profile with increased HDL and reduced triglycerides; increased insulin sensitivity; and an absolute maintenance of the, I think, very important decrease in the prevalence of subjects with metabolic syndrome, which was seen at 1 year, is carried through into the second year without any suggestion of loss of effect. About half of the metabolic effects were independent of body weight, and reflect the unique pharmacology of Rimonabant. And so the effects that are achieved at 1 year are maintained in the second year – a good 1- and 2-year safety profile, and a safety profile which, in the second year, is essentially identical or comparable to what we see in the placebo group.

And that ends my presentation. And I think we would now like to open the floor to questions and answers.

QUESTION AND ANSWER

Operator

(Operator Instructions). Andy Kocen, Redburn Partners.

Andy Kocen - Redburn Partners - Analyst

I've got a question on the commercial implications of CLARITY and COMMIT. The trial looked at ST elevation in MI patients using Plavix plus aspirin. And I only looked at one month of therapy. So by my calculations, using \$100 a month of Plavix and a 400,000 patient base globally that you mentioned, that's sort of less than \$100,000 potential sales globally per year.

I mean, I guess there is a possibility that you're looking to get these patients to stay on Plavix post the 1 month. But there's no real evidence of benefit in these patients, I don't think, because CAPRI (ph) looked at ST elevation and MI, but only used Plavix monotherapy, and CURE looked at Plavix plus aspirin combination, but in non ST -elevation MI patients. So could you just comment on the commercial implications with regard to those points?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

In fact, CAPRI looked at patients with ST elevation MI except that the recruitment started 1 week after the event. At least, there was a window for recruitment – at the 1 week, starting event (ph) up to 35 days. So what was missing so far was the early part of the treatment.

In terms of calculation, I'm not a marketing guy. So I will not make calculate about the potential market. What we still may think that you are not thinking through (ph) a therapy that is initiated from the beginning, that-- which is added during the treatment (multiple speakers)

Andy Kocen - Redburn Partners - Analyst

Sure, but CAPRI (multiple speakers)

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

In terms (ph) of compliance for the full treatment, once we have an event, you may expect that it will reinforce the compliance of the patient, especially following MI – ST-elevation MI.

Andy Kocen - Redburn Partners - Analyst

Sure, but I mean the CAPRI population looked at Plavix versus aspirin, rather than Plavix plus aspirin, didn't it? So there's no real evidence beyond 1 month that the combination does any good in this patient population.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Yes, you can extrapolate from the CURE population that in fact, when you add the 2 in this population, you have the benefit. And I'm quite sure that a lot of cardiologists, some neurology (ph) for some type of stroke will agree with you. I think that from neurology (ph) -- I do not have the number. But a lot of patients following MI are treated by an addition of Plavix plus aspirin. In fact, CHARISMA also will give you a kind of information about that.

Andy Kocen - Redburn Partners - Analyst

Okay, and just 1 follow-up question. In COMMIT, I think the number needed to treat was 1 death per 200 treatments. Do you think that compares favorably to other treatments in this area? Do you think it's pretty compelling?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

But (ph) it's pretty compelling because we are speaking in terms of total death. And you can look at the number of compound -- we've got the positive results on total deaths. B compound -- I'm not sure that's stating (ph) in terms of total death. But just to give you an information, and stating (ph) a very good product.

So after that number, you have to put it in front of the cost of the therapy. I think you have mentioned at the beginning that the benefit for the Company is not huge at the early part. So the cost of the treatment was evaluated this morning at \$100 for the full -- at least in global worth. I'm not speaking only for the U.S. But I think it's a very effective and very inexpensive therapy and it's not me saying that. In fact, it is the Jimmy Group (ph) and Professor Brungard (ph).

Operator

Matthew Weston, Lehman Brothers.

Matthew Weston - Lehman Brothers - Analyst

A couple of questions regarding the RIO-Europe study. Firstly, could you let us know how many patients have now been on drug with Rimonabant for 2 years, basically combining the RIO-Europe and RIO-North America studies?

And also, could you touch on some of the more unusual CNS side effects? You've given the data in sort of broad bands. But there's clearly been some concern from clinicians around issues such as epilepsy and people losing their memory. Can you touch on whether or not there have been any other significant differences in CNS side effects in some of the smaller areas?

And then finally, in RIO-North America, we also had a problem, if I remember, with ectopic pregnancies, which surprised many people. Can you touch on whether or not that's also been seen in the RIO-Europe study?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Yes, I can try to answer some of those questions. In terms of the number of patients who would have been on drug for 2 years, I would expect we would be approaching about 500 patients on the active treatment for 2 years.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Your question about the unusual CNS side effects in terms of -- epilepsy, I think, is what you mentioned. At the present time, we have -- no concern has come out of the data in terms of other, as you would call them, unusual CNS side effects. I think at this point, we have looked at the database fairly closely and no concerns have arisen. And as you know, we're well along in amassing the entire database.

When I mentioned the 500-patient figure for 2 years, that was approaching that at the 20-milligram dose. There are about an equal number of people who are on the 5-milligram dose. I just want to clarify that point.

So the first question was the number of patients, the second was unusual side effects, and the third one was ectopic (multiple speakers)

Matthew Weston - Lehman Brothers - Analyst

Ectopic pregnancies, correct.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

We have, in the entire RIO program, a relatively small number of pregnancies, as you know, that patients who entered the study were ST (ph) -- at recruitment had to agree that they would not try to become pregnant and that they would use contraception. So the number of pregnancies is quite small.

We do have some more pregnancies in the active treatment group than in the placebo group. And it's well-known that weight loss in women is associated with an increase in fertility. This has been seen with drugs of other mechanisms. So I think we need to put that in context.

Given the small number of pregnancies and given the number of pregnancies in the active treatment group versus placebo, at the moment, we have no signal to suggest that there is a problem with ectopic pregnancies. And I think that we would obviously need to reflect the fact that women entering the study were required -- requested not to become pregnant, so that we have very limited data in women who are pregnant.

So I think that I would disagree with the assumption that we had a signal. I don't think we do. I think that the number of pregnancies is extremely small. We wouldn't be able to pick up a signal. We don't have enough experience, and that the patient population we have looked at is one which are older women who were not attempting to become pregnant. And so I don't think we can draw any conclusions from the study about the question you asked.

Matthew Weston - Lehman Brothers - Analyst

Perfect, just one quick follow-on, if I may. The 500 patients who have been on 20 milligrams (ph) for two years, given recent events where we've seen problems in a patient population basically double that, where just post 2 years, we saw a considerable safety signal, do you still remain confident that there is sufficient data to satisfy the FDA on some of these more unusual CNS side effects? And could you just reiterate that you remain confident that the FDA is likely to review this data as a priority review, and you may well get an answer post-filing within 6 months?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

I think you are asking two kinds of questions. The first question in terms of extension of the duration of treatment, I think that for the registration of the drugs, close to 1,000 patients follow up to 2 years is quite extensive. And in my memory for the (indiscernible), most of the study was on short-term. So I don't think it can be applied.

When you are thinking about the CNS events, you need always to put it in view of the disease that we are treating. And you can go back to the package of the synical (ph) and ciprotronine (ph) and you can see that for these 2 compounds, that we can take synical, which is not supposed to have any kind of CNS effect. We have also quite the doubling of the decreasing events within the population treated by synical.

What I want to say that-- what we are observing with Acomplia, it's difficult to differentiate what is due to the effect of the treatment and what is due in fact to the possible side effects. Anyway, what we have observe in depression (ph) is always minor and yesterday, Professor Van Gaal reminded that in terms of severity, as is for RIO-Europe, the severity in CNS events based on HED (ph) scale was strictly superposable (ph) and was also very transient, as said Doug previously, the tolerability during the 2 years is strictly superposable to the tolerability of first year. You

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

may expect that with the drug, with very bad CNS events, you will have an increase at least in terms of severity in the events with prolonged exposure, which is not the case.

(multiple speakers) On the review, we always said that we will ask for priority review. We have good argument within our registration package to have priority review. At the same time, and we always said that, that in terms of launch of the compound, it will not change too much. Just because if we got priority review, we'll get registration at the end of this year. And the launch cannot be anyway before February or March. And if we have the classical 10-month review, it will get in April only. So in terms of marketing, the difference is not striking.

We have argument (ph) -- and again, we have an extensive safety evaluation of our product. You need to put it in perspective with other dossiers for prolonged treatment at the same time. In fact, it was unfortunate at the beginning, because we are in the field of morbidity (ph). And in the field of morbidity, FDA had very bad memory. So, we've had a lot -- we had to do specific (indiscernible) survey, even without signal. We had to do a specific CNS survey, even without signal. We have to treat a lot of patients for more than 2 years -- for up to 2 years, which is the -- I think it is the only disease we just cannot request (ph) them.

So in terms -- we never said that we are totally sure about the safety profile of the product. Everybody knows that we may have a little event that are infrequent that we are not able to pick up during the initial development. But in terms of initial -- again, we need to put it in perspective. We have absolutely no signal in kidney, we have no signal in the heart, we have no signal in the liver. We have a small signal in CNS, but it is partly mixed with the activity of the drugs. And anyway, it is mild and it is transient. So, and -- Doug?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Yes, and I think there's one other point that should be made. The first study that was done with this drug was a small Phase II study which was done in patients with schizophrenia. If there is a population that is more vulnerable to mood alterations and mood swings, it's patients with schizophrenia. Those results were published. They didn't show any benefit of Rimonabant in that target. But they showed absolutely no evidence of deterioration in a very vulnerable CNS population. So I think that we are and we continue to be optimistic, and with more duration of therapy and more patients being treated for longer, we're actually quite confident in the tolerability and the safety of this product, as much as you can be in a database of this size. And as everybody on the phone knows, the possibility of a very rare adverse event isn't known until you get into large numbers. But that's a caveat for any drug in development. And this is going to be as large a database for filing a new chemical entity as has been seen in -- certainly in this therapeutic area.

Operator

Jean-Jacques Lafier (ph), Auto Securities (ph).

Jean-Jacques Lafier - Auto Securities (ph) - Analyst

Question about COMMIT trial -- as COMMIT was done in China, will you be authorized to use it for finding in U.S. or EU, for example -- I would say non-Chinese countries? And if not, will you need some bridge studies, or what will you do?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

We will respond as Gerard Le Fur, that we are not discussing what we are doing with the authority without full approval of the authority. But with COMMIT alone, there might have been a problem. When you look at the wonderful complementarity of CLARITY and COMMIT, even knowing that the American College of Cardiology recommends in fact to put now Plavix first-line in MI in these guidelines. We're not expecting too much problem to register with COMMIT and CLARITY.

Jean-Jacques Lafier - Auto Securities (ph) - Analyst

But, if even if COMMIT is was done with Chinese patients --

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Yes, the Chinese patients so far for Clopidogrel they are responding as the other people. You need also to be aware that the treatment in China was roughly the same as in Western countries. The only difference was the (indiscernible). So they were more using stratortenize (ph) than TPA. But so far in terms of results, you see the same results. You see the tolerance.

So I do not-- and also you need to know that we are a little bit positive (ph) by the idea that any patient in Europe would get PCI or any in the U.S. And it was said this morning -- you have a lot of community of people who are not aware that PCI within a short term is not a variable and where you will use Clopidogrel.

So I think, in terms of global health -- and again, it is very unusual to see positive data on global mortality. And I said that Metoprolol, which is a very good and very well-recommended product, fell (ph) in terms of global mortality in this study. So I think the study are very robust. The 2 studies are very robust. They are very -- reinforcing each other, and also, because we have also the information on aging patient.

Operator

Mark Purcell, Deutsche Bank.

Mark Purcell - Deutsche Bank - Analyst

Thanks very much for taking my questions. I have four. Just in acute myocardial infarction, just wondered if you could remind us of the penetration rates for Plavix in both the U.S. and in Europe. Clearly, as you just said, there's an extensive STEMI (ph) population in the U.S., and penetration therefore could be quite high.

The second question on RIO studies -- I just wondered if you could run through some of the more important exclusion criteria in the RIO studies?

Thirdly, again, on RIO, I just wondered -- you were saying that roughly about half of the benefit on HDL and triglycerides is independent of the weight loss benefits from Rimonabant. I was just wondering on the insulin secretion side -- on the HOMA measurements, what proportion of the benefit there you feel is weight-independent?

And then the last study is just a follow-up -- you were talking about the schizophrenia Phase II study. I just wondered if you could remind me the length of treatment in that study and how many patients were followed?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Okay. Let me start with the exclusion criteria. Basically, the study excluded people who, in the view -- obviously, in the view of the physician, had major systemic illness other than those which are of interest. The major exclusion criteria in the studies that we've reported were Type II diabetes. But as you know, there is a study which is still under evaluation and which will be reported in July which is restricted to people with overweight and obese -- who have Type II diabetes. The inclusion criteria, as you know, were based on body weight -- BMI greater than 30 or BMI greater than 27, if they had a comorbidity.

The exclusion criteria were largely focused on those elements which would interfere with the primary endpoint, so that, for example, medications which would affect body weight such as antidepressants, anti-neuroleptics, etc., patients were excluded. Patients were also excluded if they were interested in attempting to quit smoking, because smoking, again, confounds the primary endpoint, which is the measurement of body weight. Patients were excluded if they had severe depression, as demonstrated, for example, by a previous suicide attempt or hospitalization and so forth.

Other than that, the inclusion criteria were quite broad. We didn't have an upper limit on age. We didn't have an upper limit on BMI. And so we think it's a relatively representative population of that which is going to be treated. And again, we excluded women of childbearing potential who were not -- who were either interested in becoming pregnant and were not using contraceptive. We excluded women who were breast-feeding and so forth. So the usual types of pharmacologic considerations for a new drug. But really nothing beyond that.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

For the -- oh sorry -- (multiple speakers)

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

No, I think they had (multiple speakers)

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Excuse me -- so, for the treatment of schizophrenia, it was the classical 8-week (ph) treatment in schizophrenia. For Plavix, I did not pick up fully the question --

Mark Purcell - Deutsche Bank - Analyst

Mark, it was just simply in terms of the penetration into the AMI or the STEMI/non-STEMI populations -- what it stands at maybe prior to the presentation of COMMIT and CLARITY in the States, and also outside the United States?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

I think what we changed, that there is more and more evidence that you need to treat earlier. And so far, it was not possible to give Plavix to any patient with suspicion of MI, just because we have no information in acute MI and I think that now we have information on acute MI. And also because of the fear that if patients were receiving Plavix very early, there was the risk of bleeding if there was ongoing CAVH within the next 5 days. And I think that both the results of CLARITY and COMMIT are showing that Plavix is very efficient, and is more efficient when it is administered sooner. And at the same time, that in terms of bleeding, at least in CLARITY, there was no effect on bleeding during CAVH. I think what would change in the therapy and some (technical difficulty) some professor was speaking of the magic pill, but it's not a magic pill. But it's a combination -- in the ambulance, as soon as you have a signal or possible myocardial infarction, the association of aspirin with Clopidogrel.

Mark Purcell - Deutsche Bank - Analyst

Sure. And Doug, could you just address the question in terms of the impact on insulin of Rimonabant as well -- what proportion of the impact do you believe is not related to weight? And I just wondered also if there's any update you could give us on the impact on LDL cluster (ph) over a 2-year period, too.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Sure. The question -- the question that you're asking is on the HOMA -- is it the insulin resistance or the insulin secretion part?

Mark Purcell - Deutsche Bank - Analyst

Either, just in terms of the effect that you're seeing through the study relative to placebo, what proportion do you believe is weight-independent?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Right, about in -- we do have evidence that the insulin resistance measurement of HOMA is weight-loss independent, again, about half of it, which is consistent with the other pieces of information that we've given.

Your question about LDL changes -- that was look that most completely in the RIO LIPIDS study which was in patients who also had dyslipidemia, in which a whole additional panel of lipid analyses were done. Although the LDL cholesterol concentration didn't change, there was a significant shift in the LDL particle size distribution with the decrease in the small, dense, atherogenic LDL and an increase in the protective, large, light, buoyant LDL particles. So that's one point.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

The second point is that if you look at the ratio of apoA to apoB, which is probably the most important parameter in terms of the balance of the atherogenicity or antiatherogenicity of circulating lipids, there was a strong benefit on the apoA/apoB ratio.

And so, I think that we are looking beyond LDL cholesterol as the sole measure here. We're looking at the atherogenicity components. This was accompanied by a consistent and marked reduction in CRP, C-reactive protein. So I think short of doing a cardiovascular outcome study or doing an IVIS (ph) or an IMT study, all of which we're clearly going to do, this I think from a metabolic and lipid compositional perspective, we can say that we have a profile that should be associated with a significant improvement in cardiovascular risk.

Mark Purcell - Deutsche Bank - Analyst

And the profile that you saw in RIO LIPIDS that you just eloquently described, you saw that also in RIO-Europe 2 years, did you? (multiple speakers)

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

(multiple speakers) To the extent that we measured it, we saw the same thing. We didn't do all of these additional measurements in RIO-Europe, because of study size and so forth. Those were focused primarily in the RIO LIPIDS study.

Operator

Michael Leacock, Nomura.

Michael Leacock - Nomura - Analyst

I have a few questions, starting with the very briefest, the slightly longer one. How many patients were on Rimonabant 20 milligrams for 1 year, if you could answer that one?

Secondly, could you talk a little bit about the challenge in obese diabetic patients? I think that's the next dataset that we're looking for. What's the main difference between the obese and the obese diabetes patients, apart from the obvious, and particularly, in terms of your product, what challenges might it face in delivering similar weight loss in those patients?

And perhaps thirdly, if I could ask, how do you realistically expect Rimonabant to be used in clinical practice? I think particularly with the sort of slight weight loss drifting upwards over time, is it a credible and reasonable expectation that it will be used chronically, or do you expect it to be used in pulse (ph) therapy? I'd just like to have some idea of where you think this would fit in clinically.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Okay, that's a lot of questions altogether. So let me start with your last 1 first. And I guess I would first quibble a little bit with the assumption on which your last question was based. And that is the suggestion that there's a bump upwards in body weight. If you look at the curves, both in RIO-North America and in RIO-Europe, essentially the placebo-subtracted difference, that is the drug effect, is essentially sustained. Placebo group tended to wander up. And so I think I would not accept the assumption that the drug has a waning effect on body weight. That's the first point.

The second point is -- and it gets into your next-to-last question -- we are looking for patients who have serious medical problems related to metabolic syndrome, overweight, increased cardiovascular risk. We're looking to benefit those patients in terms of their long-term cardiovascular risk. If you look at the fact that the frequency of metabolic syndrome, which was reduced by half at 1 year remained reduced by half at the end of the second year, I don't think the question of what happens to absolute body weight is really the relevant point. You could expect that perhaps both the placebo group and the active treatment group -- maybe the active treatment group is gaining subcutaneous fat, but not intra-abdominal adiposity. Maybe they are gaining lean body mass because they are more active and exercising.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

I don't think that's the real relevant point. We're not talking about a weight-loss drug here. We're talking about reducing cardiovascular risk. If you reduce the frequency of metabolic syndrome by half at the end of the year, if you sustain that benefit, that, to me, is a permanent, sustained benefit that the patients achieve.

The question is is this going to be used for pulse therapy or is this going to be used for long-term therapy? That was the major point of the RIO-North America study. What we demonstrated was that if you -- metabolic syndrome, the increase in cardiovascular risk associated with being overweight, having a high waist circumference, is a chronic disease. If you discontinue the drug, you lose the benefit. And it would seem to me almost unconscionable to propose this as a pulse therapy when we're dealing with long-term cardiovascular protection.

So I think this is -- I think we feel, and the investigators who have studied the drug, I think, feel quite strongly that we're dealing with a chronic disease. And it needs chronic treatment. And Rimonabant provides an important benefit in terms of long-term cardiovascular risk profile. I know I didn't answer -- what were your other questions?

Michael Leacock - Nomura - Analyst

Just the number of patients on the 20 milligrams.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Oh, the Type II -- you were asking about the Type II diabetic population? As you know, we have a study -- patients with Type II diabetes were excluded from the 3 studies that we've presented. We have a fourth study which is specifically focused to answer that question. We'll be reporting that at the American Diabetes Association. And so I think it would be inappropriate for us to discuss that until you all had time to see the data and it was looked at by experts in the field.

So I'd rather not make a comment on that, except to say that when we look at the insulin sensitization that we enhance with Rimonabant; when we look at insulin resistance as being the primary driver of for the development of Type II diabetes; and when we look at a piece of data which I didn't actually show you, which is the patients in the RIO-Europe study in terms of their change in glucose tolerance category -- that is, we did glucose tolerance tests; we had some people who were normal glucose tolerant, some who were impaired; we had a small number who had diabetic glucose tolerance tests when they entered -- if you look at the effect of the drug on distribution of patients among those categories, at the end of 2 years, we're actually showing a statistically significant improvement in the categories of glucose tolerance among the patients. This would lead us to postulate that an important potential use of Rimonabant going down the road in the future would be in the prevention of Type II diabetes. And this is something that I think we're very interested in looking at.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

And may I add something? And in order to disassociate a little bit just weight and metabolic disorders, it is interesting to note that at 1 year, we're not positive in terms of difference for the patient for insulin resistance and we were positive at 2 years. So somewhere -- again, we are not thinking of Acomplia -- and I'm just paraphrasing what is saying Doug -- I'm not saying we're not looking at Acomplia as a weight loss product. We are looking at Acomplia as a treatment for metabolic disorders linked to ability (ph). And when you're looking at Acomplia like that to all the different parameters, we have a perfect maintenance of the different, and even some improvement in the ability (ph), of these parameters in 2 years.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Is that all your questions?

Michael Leacock - Nomura - Analyst

Yes, thank you very much (multiple speakers)

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Is that all your questions?

Michael Leacock - *Nomura - Analyst*

I did have just 1 question on the 20-milligram dose – patients who were on it for 1 year. What was the total number?

Douglas Greene - *Sanofi-Aventis - VP, Development and Medical Affairs*

I'm not – I would expect that we're probably more than 2,500 patients who are on Acomplia for 1 year at both doses. And I would expect about half of those were on 20 milligrams. But, I'd have to check that figure for you. I don't know that off the top of my head.

Mark Cluzel - *Sanofi-Aventis - SVP, Development and Scientific Affairs*

(laughter) I'm sure you could calculate its for eternity. I'm sure it's more than 2,000. Perhaps close to 3,000. I don't know.

Operator

Ben Yeoh, ABN Amro.

Ben Yeoh - *ABN Amro - Analyst*

I was just wondering on your discontinuation rates, have you done the statistical analysis, particularly with discontinuation to adverse events – i.e., I was just wondering versus placebo, is the high continued -- discontinuation rate significant to what level? Is it just P less than 0.05, or is it 0.001? And similarly, have you done the sort of analysis on particularly the CNS side effects? How significant are they, or are they only marginally as significant statistically?

And then secondly, I was just wondering whether you have an idea at this stage how many sections of the FDA you think your filing will have to go through? Obviously, it's probably going to go through at least 2, with this making cessation (ph) part. But with the extra safety bid (ph) and the other department that may be involved, I'd don't know if you can give us an idea of that at this stage?

Douglas Greene - *Sanofi-Aventis - VP, Development and Medical Affairs*

Let me start with the question about statistical significance of looking at adverse events. We don't – first of all, the design of the study -- the question of statistical significance of frequencies of discontinuation and so forth I think are not a proper use of statistics. We've presented the safety database with regard to discontinuation rates for adverse events in 3 large studies – and in 2 of them, both at 1 year and 2 years.

And the results are consistent from study to study. We show an increase in the frequency of discontinuation due to adverse events in the first year, whether it's -- the exact figures vary from study to study. But we've seen it in every study. So we think it is what it is, and it's consistent. We've not done statistics on it. But we think it's a consistent finding, which is I think the proper way to catch it. The important thing is (multiple speakers)

Ben Yeoh - *ABN Amro - Analyst*

But the FDA would probably do some statistics on it, would it not?

Douglas Greene - *Sanofi-Aventis - VP, Development and Medical Affairs*

I don't know whether the FDA would do statistics on it. I think what they would do is that they would look at the numbers and they would show the numbers as what they are. And I think they would deal with them exactly the same way as we've done. If it's consistent among several large

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

studies, it is a robust finding, whether you put a P value on it or not. And people don't know whether it should be a P less than 0.1 or 0.05 or 0.02. So most statisticians don't like to do that.

It's a consistent finding. And we don't dispute that. We've been quite open about that, I think. And so it's a real finding. The important things are that number one, those discontinuations occur in the early part of the study. The discontinuation rate due to adverse events in the second year of, now, 2 large studies is identical to placebo, so that it says that we're not dealing here with some sort of a modification of the biology of the organism of the patient that continues to accrue, which is what you really worry about in terms of long-term treatment. It's adaptation to a new pharmacology. And some patients are going to develop nausea; some patients are going to report depression; some patients -- and so forth, and so on.

So I think the statistical question I think really isn't the fundamental question. The fundamental question is, what is this drug going to do when it gets out into the marketplace and when patients are on it on chronic therapy? And the fact that some patients discontinue early in treatment -- that's probably true with any drug. And I think the FDA is more sanguine, more comfortable with tolerability problems that lead patients discontinue rather than safety problems that accrue with chronic therapy. And we have no evidence of any chronic safety problem that accrues with therapy. Mark, I don't know if you have anything to add?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

No, just that in fact, the dropout rate was similar between the 2 companies, because if you have a different dropout rate, you may have some difficulty to interpret your data. But we have totally -- and in fact, so far, I think it's early, because this dropout due to adverse events happened early during the trial. So in fact it's in disfavor (ph) of Acomplia, because in the last observation carried forward, we have less activity then we should have.

So far, we will be with 2 divisions, which is endocrinology and SRG (ph) -- you say that because of the safety profile of the drug, we'll have another -- and so far, when at the beginning of the Phase III, when endocrinology has some problem, we categorize too (ph) -- at least they won't (indiscernible) some help. They ask help from cardiovascular. I do not see which other division will be involved at the present time. And perhaps you're thinking in terms of CNS. But in terms of CNS, the signal is very small.

Operator

Lucas Herrmann, Deutsche Bank.

Lucas Herrmann - Deutsche Bank - Analyst

A couple of questions, if I might. The first I wanted to ask you is just on the cardiovascular profile and whether you could make any comments on the lack of changes in blood pressure, which given the scale of the weight loss, seem somewhat surprising. I think typically, you go and see a physician, and if you're overweight, the first thing he tells you in terms of getting your blood pressure down is, well, lose some weight and that will follow. And at 2 years, we seem to be saying no change. Is that masking something? Are some patients seeing a rise in blood pressure, and others seeing a fall? Perhaps you could just explain the difference?

And secondly, it goes back to Michael's question earlier on the nature of the drug. The numbers I've seen suggest that you got something like a 55 percent or so dropout on the 20-milligram arm over 2 years relative to near a 58 percent placebo. And simply looking at the data, one's impression is -- great slimming treatment; effective weight loss very quickly. But how are you going to convince people to stay on this drug for the long-term, so retain the cardiovascular and metabolic benefits, wherein you're seeing such high levels of fallout in a clinical setting?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Sure. Let me take the blood pressure problem and then the dropout question. With regard to blood pressure, when you lose weight, you do see usually a small decline in blood pressure. It usually occurs quite early after beginning a weight loss program. And we need to remember that these patients had already been on a weight loss program for a month before randomization. And so, there was a small drop in blood pressure during the running period, which is when you would expect to see most of the benefits of weight loss on blood pressure. So it's confounded by the study design, in that that small drop in blood pressure occurred during the initial 4-week running period. That's point number 1.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Point number 2 -- we've looked very carefully for what you are alluding to -- that is, is there a population of patients who, as with some of the current antiobesity drugs -- which is I think -- we still say is a different category from the way we view Acomplia. But for example, in the sibutramine, you have a small group of patients who actually -- although they lose weight, their blood pressure goes up. And we do not see any hint of that kind of distribution within our very large database.

The next point is that when you look at subgroups, if you look at patients who are hypertensive to begin with, either because they were on treatment for hypertension or because they were found to be hypertensive at baseline, those patients actually do experience an improvement in their blood pressure.

And the final point was that these studies -- it's important to look at all elements of the metabolic syndrome. We've done a study in patients with dyslipidemia where that was an important prespecified endpoint. We've done a study, or we're doing a study in diabetes where glucose control is an important prespecified endpoint. In the Phase III program thus far, we haven't done a hypertension study, which would be designed to look specifically at that question. So we're left with subgroups. And in those subgroups, we get results which are comforting.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

And now, the chronic administration (multiple speakers)

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Chronic administration, yes (multiple speakers)

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Within the physician (ph) metabolism (ph) --

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Yes, I think we're dealing here with how physicians and patients view Rimonabant and what their expectations are. If patients and physicians view this as a weight loss drug, a body composition drug, and if their expectations are that they're going to go from being obese to slim with pharmacologic therapy, you're right. They're going to be disappointed.

Now, when we started the Phase III program because of the nature of the program and so forth, that was the expectation that many of the patients had coming into the study. It was unavoidable, given the fact that the profile had yet to be established. So the dropout rate mostly reflects the expectations that the patients had coming into the study. We didn't have the data and the positioning to modify that expectation before they come in. That's why it is so important for the data that we have been collecting and continue to collect to be known to physicians, known to patients, know that the target here is cardiovascular risk, not cosmetic improvement. Patients stay on statins not because they feel better, not because they look better, but because they want to avoid a major cardiovascular event. Patients stay on aspirin for the same reason. So we don't think that the dropout rate in the clinical trial is going to reflect real-life, because physicians and patients are going to have a different set of expectations once they see this data.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Also, if you are looking at RIO-North America, you know that there was a real randomization after 1 year. And surprisingly, in fact, the dropout rate in the 20-milligram -- so in the patients who are continuing Acomplia, was lower than in the patients who were transferred to placebo. And you have to link that in fact with the quality of life. All the people taking the drug in terms of quality of life perceive an improvement on Acomplia. So it is perfectly true that if the drug is positioned as a weight loss product, it will fail as any other kind of weight loss product. But as soon as you are touching (ph) the obese population with metabolic disorders linked to obesity, when they are on-drug for some time, obviously, they are perceiving the benefits of the drug, which should be of some help for chronic treatment.

Lucas Herrmann - Deutsche Bank - Analyst

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Can I just follow 1 thing, since we've talked a little bit about diabetes here, I wonder -- have you taking any measurements of HbA1c? You've talked about farcing (ph) plasma glucose, and you've talked about insulin sensitivity -- any HbA1c measurements through the Europe or the North America trial?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

It will be presented at ADA, because during RIO-LIPIDS, it was one of the endpoints.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

But we haven't measured at in the existing studies. You wouldn't expect to see a change in hemoglobin A1c when you excluded diabetes. We will obviously have those results for the RIO diabetes presentation at the American Diabetes Association.

Operator

Timothy Anderson, Prudential Equity Group.

Timothy Anderson - Prudential Equity Group - Analyst

A few questions. Can you describe exactly how you determine that metabolic changes are independent of weight loss, which is one question?

And then the other question I have is -- just hard outcomes data of any sort-- any sort of rough timeline for when you might have hard outcomes data on things like CV mortality. And then suicides -- I'm sure the question has already been asked before, if not on this call. But can you talk about aggregate suicide rates across the 4 pivotal trials with placebo 5-milligram and 20-milligram?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Yes, your first question again was?

Timothy Anderson - Prudential Equity Group - Analyst

The first question I had was how do you determine that metabolic changes are independent of weight loss?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

So let me see if I can state this in a clear and concise way. There are several approaches that were used. The one that we have presented is based on a statistical approach in which one examines the relationship between body weight and the parameter in the placebo group, and examines that same relationship in the active treatment group in which you correct for any differences in weight change between the 2 groups. And there are a variety of statistical approaches to do that from linear regression analysis or multiple timepoint analysis and so forth and so on.

So the figure that we've given, which is that about half of it is independent of body weight, was based on a statistical approach. And I can go into more detail if you'd like, but I don't want to burden -- go above and beyond -- get into a statistical lecture here.

The second way to do this, which we've also done is to look at the -- across categories of weight loss. So you take people in both treatment groups who didn't lose any weight -- you know, a group whose weight change was zero to plus 2 kilograms. And then you look at a group who lost between zero and 2 kilograms, and between 2 and 4 kilograms and so forth. And you compare the metabolic profiles within those weight change categories. We've done that, and that across the board reinforces the statistical approach.

And then the third approach is to look at the time course, which is more of a qualitative measure. And what you see when you look at the time course is that there is -- when weight loss plateaus, you're still continuing to show improvements in metabolic parameters.

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

So it's a multipronged approach. These were prespecified in our statistical analysis plan. This isn't something that -- it's based on the preclinical data. It's based on our understanding of the mechanism. So it was a prespecified analysis. And the 3 approaches each reinforce the same finding. They are consistent across each individual study. They become even more robust when you do it on pooled analyses. And so we're quite confident in the robustness of this finding.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

On suicide, in fact, we have no signal. And if we have one signal, it is in placebo. So, no problem. And again, it's also interesting to have the schizophrenia data, because you know that in this population, you have high adiation (ph). And we have some, and definitely is not in the favor of 20 milligrams.

So for suicide, it is an excellent question. We still continue to look at that. But so far we have no signal for 20 milligram and for 5 milligram, of course.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

(multiple speakers) timelines for --

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Oh, the timeliness, the true ones, of -- I think -- we will have both diabetes and cardiovascular -- cardiovascular definitely not before 2009, something like this. For prevention of diabetes, you should consider that as a morbi-mortality trial. It might be a little bit sooner.

Timothy Anderson - Prudential Equity Group - Analyst

Okay, and then, if I could just ask one more question, which is just going back to one of the first questions on ectopic pregnancies, were there any ectopic pregnancies at all? And if there were, can you give us the numbers in each of the groups?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

That's a good question. The question about ectopic pregnancy -- I think there were a couple. There was one that was a potential ectopic pregnancy. It was not definitively diagnosed. But there was a suspicion of one. There was a second -- there was 1 ectopic pregnancy which was quite clear. It was in a woman who had a tubal ligation.

So I think that, again, we have no signal. I don't remember which groups they were in. But we're dealing with what I think is absence of a signal. So we had one which was in someone who had a tubal ligation, and a possible second one. And I'm sure that one of them was in the placebo group. I don't remember which one the other one was in.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

But again, I think that the total number of pregnancies should be 39 during the program. So with 39, to exclude any kind of signal, positive or negative, is difficult.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Yes (multiple speakers) we just don't have enough data (multiple speakers) but we don't have a signal.

Operator

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

James Terrill, Capital Research Global Investment.

James Terrill - Capital Research Global Investment - Analyst

You alluded to this earlier, and I wondered if you had done some more rigorous analysis to have the answer. But if you look at the absolute change in weight, i.e., the degradation, if you will, of weight loss in the second year in an absolute sense, were you able to analyze any of those patients and understand whether it had something to do with an increase in lean body mass, which is obviously heavier than fat, and/or something like lower compliance or something else?

The second question I have is when you look at the weight reduction and other efficacy parameters, are they increasing as a function of increased BMI -- i.e., are the sicker patients accruing more benefit?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Okay, I think it was presented the 1st of March. So you have to go back to the presentation made to the financial analysts (ph) 1st of March. Well, definitely when you're looking at the above 40 BMI, in fact, the fall is more drastic. And you start to -- in the classical population, you have an inflection of the curve starting at 9 months, where in the data we presented up to 1 year, you have you see there's a full decrease. And I think also we have a difference of 2 to 3 kilos between above the 40 -- or 6 pounds above 40 and below 40.

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Yes, I think the data were presented at the analyst meeting. You can find them on the website. We're talking about 11 kilograms of weight loss at the end of the year. And I think, as Mark indicated, the benefits are magnified. And I think that there's also a very interesting finding in the patients with extreme or severe obesity. And that is that in this study -- these are probably would be considered perhaps fragile patients; they carry a lot of disease burden -- the discontinuation rate due to adverse events was essentially identical in placebo and in the Acomplia 20 milligram. So we were actually quite happy with the risk/benefit ratio in these people with severe obesity, for whom there is no product out there short of surgery that actually has been shown to be effective. So I think -- and again, you can find all of those data on the Sanofi website. You have to click on the financial section (multiple speakers) because it was -- pardon?

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

The Investor Relations (multiple speakers)

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Investor Relations area, because it was presented at the analyst meeting.

James Terrill - Capital Research Global Investment - Analyst

And the first question?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Which was --?

James Terrill - Capital Research Global Investment - Analyst

(multiple speakers) on the absolute changes in body weight, whether you had a sense as to whether it was attributable to changes in body mass or something else -- compliance, other?

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Yes, we haven't done body composition studies in the Phase III program. So I can't tell you whether the extent to which -- what we'd like to know, and we think we do know indirectly from the metabolic syndrome measurements, from the adiponectin measurements that we see in RIO-LIPIDS, we think that we have a very positive effect on intra-abdominal obesity, which is the worry.

Do we know -- we don't at the moment have the body composition studies to be able to definitively say as a function of time when we're affecting the dangerous intra-abdominal adiposity versus the rest of the body fat. We'll get that. It will take time to get. So I wouldn't be able to speculate on answering the question that you proposed, except to say that the best surrogate measure that we have of intra-abdominal adiposity is metabolic syndrome, HDL, triglyceride, and insulin resistance. And those benefits -- they are maintained in the second year. And in some cases, they actually continue to improve.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

Operator, we take one last question, please.

Operator

Rajna Upadia (ph), UBS.

Rajna Upadia - UBS - Analyst

I joined the call late, so I apologize if this question has already been asked. Regarding the dropout rate, I noticed that for Acomplia 20 milligrams, it was nearly double the dropout rate for depressive episodes within placebo at 3.7 percent versus 2 percent. And I was just wondering whether you could clarify whether all the patients who required antidepressants actually terminated RIO-Europe early, as in the RIO-North America trial, and also, whether there have been any patients diagnosed with depression whilst taking Acomplia therapy who subsequently prescribed antidepressants, and then who remain on Acomplia therapy, whether you have any data on that?

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Thanks for the question. The protocol required that patients who complained of depressive symptoms or who the primary -- the investigator detected, had a concern about the depressive symptoms, or had achieved a certain threshold on the hospital anxiety depression score would be referred to a psychiatrist for an evaluation. If at that time, the psychiatrist elected or recommended beginning antidepressant therapy, the protocol mandated that the patient be withdrawn from the study, because as we mentioned -- you might have missed it -- we mentioned earlier, antidepressant drugs influence body weight, and would have confounded the primary outcome of the study.

So the answer to your question is we have no data. We have -- let me put it this way -- by study design, patients who were put on an antidepressant agent would have discontinued this study. We do have some patients -- I don't know the number -- who were protocol -- despite the protocol were treated with an antidepressant at the same time that they were treated with Acomplia. But it's a very small number of patients.

Mark Cluzel - Sanofi-Aventis - SVP, Development and Scientific Affairs

But now in the new study, since we have quite certainty about the weight, in fact, we are local concomitant (ph) medication between Acomplia and antidepressants. So within a short term, we should have this kind of data available.

Rajna Upadia - UBS - Analyst

Thank you. Did you also track the outcome of patients who discontinued therapy due to depression? Did you sort of track them after they had discontinued to see whether the placebo patients had the same sort of clinical outcome as the Acomplia patients?

Mar. 09. 2005 / 4:00PM, SNY - Sanofi-Aventis Conference Call - Clopidogrel and Rimonabant at ACC

Douglas Greene - Sanofi-Aventis - VP, Development and Medical Affairs

Yes, we've actually -- we've done that. So patients who are discontinued for any reason or certainly for an adverse event were followed up. We have looked at the -- I guess, the profile of depression in the patients who were discontinued. And we find really no difference between the patients who were in the placebo group and the patients who were in active treatment in terms of the kinds of treatment that they had to receive, seriousness of depression, and so forth.

Felix Lauscher - Sanofi-Aventis - Director, North American IR

Okay, thank you, everybody, for the excellent participation. Once again, if you have follow-up questions, don't hesitate to call the Investor Relations team, either in Paris or here in the U.S. And we will then take care of further questions. Thank you so much for your participation.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

© 2005, Thomson All Rights Reserved.

Exhibit H

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Event Date/Time: Jun. 13, 2005 / 11:30AM ET

THOMSON
★

streetevents@thomson.com

617.603.7900

www.streetevents.com

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

CORPORATE PARTICIPANTS

Marc Cluzel

Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Douglas Greene

Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Sanjay Gupta

Sanofi-Aventis - Investor Relations

Felix Lauscher

Sanofi-Aventis - Director, North American IR

CONFERENCE CALL PARTICIPANTS

Andrew Brown

Morgan Stanley - Analyst

David Beadle

UBS - Analyst

Ben Yeoh

Williams de Broe - Analyst

Graham Parry

Merrill Lynch - Analyst

Sebastian Berthon

Exane PNB Paribas - Analyst

Alexandra Hauber

Bear Stearns - Analyst

Ramish Rajinturn

UBS - Analyst

Michael Leacock

Nomura Securities - Analyst

Mark Purcell

Deutsche Bank - Analyst

Julia Kennarick

Lehman Brothers - Analyst

PRESENTATION

Sanjay Gupta - *Sanofi-Aventis - Investor Relations*

Hello everybody, good afternoon. This is Sanjay at Investor Relations in Paris. I'd just like to introduce the participants in today's call. It's Dr. Marc Cluzel, Senior VP International Development, Science and Medical Affairs, who is here with me in Paris, and in San Diego at the ADA, we have Douglas Greene who's the Vice President of Corporate Regulatory Affairs, as well as Felix Lauscher from the IR team.

The format of today's call will be Douglas will briefly present the results of RIO-Diabetes, using some of the slides which were used at the Symposia earlier yesterday, and then we will take question and answers for about 40 minutes, and the questions will be answered by Marc and Douglas jointly. So I turn over the call to Felix Lauscher in San Diego.

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Felix Lauscher - Sanofi-Aventis - Director, North American IR

Yes, good morning everybody and I would just hand over to Doug Greene who'll start with the presentation that was given here last -- yesterday by Andre Scheen from Liege.

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Thank you. Thank you, Felix. Good morning, good afternoon to everybody. I'm pleased to be able to present the RIO-Diabetes results on behalf of Andre Scheen who is the principal investigator, and the slides I will use were those that were shown at the late-breaking scientific session at the American Diabetes Association meeting in San Diego.

The first slide is the title and the attribution to Andre Scheen, and if we go to the second slide the point that I think we all need to understand as we move with Rimonabant into a new target population is that there are specific and very difficult challenges in the management of Type 2 Diabetes. These patients are difficult to manage. They often [break in audio] -- problems, high cardiovascular risk, and the presence of Type 2 Diabetes in and of itself confers as much risk upon a patient as having had, for example, a previous heart attack, and that despite current therapy with statins and other types of risk-reducers, a patient with Diabetes remains at considerably higher cardiovascular risk, even with currently available therapy.

Improvement in glycemic control which can manage the micro-vascular complications of Diabetes, such as Diabetic kidney disease, Diabetic eye disease and Diabetic retinal disease, and Diabetic nerve disease, still is not conclusively been shown to reduce significantly the cardiovascular risk. And furthermore, most attempts to improve glycemic control with medication produces as a side effect weight gain, which just further complicates the metabolic situation and probably confers additional cardiovascular risk. So current medicines for the treatment of Type 2 Diabetes are somewhat of a trade-off in which you trade off improved glycemic control to reduce micro-vascular complications. But you, in many cases, sacrifice cardiovascular risk because of the associated weight gain. So there's clearly an unmet medical need.

If we go to slide 3, we find that what we've recently come to understand about the mechanism of CB1 Receptor Blockade points out the fact on -- that CB1 Receptor Blockade acts at many different levels in the body. It acts at the -- within the brain to reduce food intake and have beneficial effects on body weight in intra- abdominal adiposity. But it also has direct effects on many of the same tissues that are affected by current anti-Diabetic medications. So the PPARs, the Glitazones, worked primarily in adipose tissue and muscle; Metformin works primarily in the liver, and so here we have a mechanism of action which impacts many of the same organs through different mechanisms that are targeted by current anti-Diabetic therapy. But in addition, by the specific effects of CB1 Receptor Blockade we also have the possibility to produce weight loss instead of weight gain, and this has obvious, so unique benefit for this kind of mechanism of action.

If we go to the next slide, just to remind everybody that the RIO-Diabetes program is the last of the 4 pivotal RIO studies - Rimonabant in obesity -- which constitutes a very large clinical database of over 6,000 patients, many of them followed for up to 2 years. And the previous studies excluded patients with Diabetes and the RIO-Diabetes study is focused solely on patients with Type 2 Diabetes.

On the next slide you can see that this involved over 1,000 patients at more than 150 centers in 11 countries. It was a randomized double-blind placebo controlled trial with testing the same 2 doses of Rimonabant that had been used previously.

Slide 6 many of you are familiar with. This is a study design slide and the study design was essentially identical with the previously reported RIO studies, only the patient population was different. Patients were screened. They underwent a 4 week diet-only placebo run-in period on a diet which was reduced by 600 kilo calories per day from their calculated energy requirement. At the end of the 4 week run-in period the patients were randomized one-to-one-to-one to the 3 treatment groups -- placebo, 5 mg and 20mg -- and there were about 230 patients in each of the treatment groups.

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

The inclusion criteria again are quite familiar in many aspects. Male or female, 18 to 70 years, BMI between 27 and 40. But in this study the patients had to have Type 2 Diabetes. They had to be treated with a mono-therapy of either Metformin or Sulfonylurea, which was maintained at a stable dose for at least 6 months, and they had to be inadequately controlled on Metformin or Sulfonylurea as assessed by the International Diabetes Federation guidelines. That is the Hemoglobin A1c did not achieve the 6.5% goal and it could be up to 10%, and they also had to have elevated fasting plasma glucose between 5.5 and 15 mmols per liter or 100mg per dL, and it calculates out to 270mg per dL. They also had to have a stable weight in that they varied less than 5kg within the previous 3 months.

The efficacy endpoints shown on slide 8. Once again the primary endpoint which was used to calculate sample size and so forth was change in weight, body weight from baseline to 1 year, and pre-specified secondary endpoints - obviously in a Diabetes study, change in HbA1c which is the gold standard for assessing glucose control, was the first -- was the major secondary endpoint. And then below that were the changes that we have looked at in other RIO studies. Changes in HDL-cholesterol and triglyceride, waist circumference and the metabolic syndrome prevalence according to the ATP III definition.

Slide 9 shows the characteristics of the patients at randomization. Again 90% were Caucasian. An even split between male and female. They were in their mid-50's. Their body weight was close to 100kg. BMI was in the 34 to 35 range. Waist circumference about 110cm, and their HbA1c's at screening were 7.5 in each of the treatment groups. And it's important to remember that the - what I'm showing you at screening here - is before the 4 week run-in period on placebo and diet. So the HbA1c value was 7.5 at screening. You'll see the baseline value is a little bit different, representing the impact of the 4 week run-in period. And these patients were relatively -- had moderate duration of Diabetes and that they had Diabetes on average of 5 years.

As I indicated in my introduction, patients with Diabetes have high cardio metabolic risk. Almost two thirds of them had hypertension. More than half of them had dyslipidemia. About two-thirds of the patients were treated with Metformin, one third with Sulfonylurea and this is entirely appropriate given the fact that Metformin is considered by many specialists to be the therapy of choice, background therapy of choice for patients with Type 2 Diabetes who are overweight, and 80% of the patients had metabolic syndrome.

If we now look at the efficacy results - and I'm jumping to slide number 12 - you can see that once again there was a significant dose and time-dependent loss of body weight and reduction in waist circumference with achieving in the completers almost 6kg of weight loss, versus from baseline. In the active treatment groups the LOCF-ITT data are shown in the figures above. These numbers are quite impressive, given the fact, as I indicated before, that most anti-Diabetic therapies cause weight gain. And secondly, it's been well established that people with Diabetes are much more resistant to weight loss than other non-Diabetic individuals, and there are lots of reasons to -- scientific reasons to support that. Again, a parallel reduction in body weight and waist circumference.

And if we go to the next slide, slide number 13, which looks at the percentage of patients who achieved clinically meaningful weight loss, we find in the ITT analysis that just about 50% of the patients on 20mg achieved a weight loss of 5%, which is virtually identical to that which has been seen in the other RIO studies. It always comes up pretty close to about halfway in the ITT analysis.

If you look at the 10% weight loss which, in this situation would be more than 10kg or over -- well over 22lbs, we find again an almost eightfold, seven to eightfold increase over placebo in the responder rate at achieving a 10% weight loss.

We now come to what I think is the most important new data and that is the real potential for Rimonabant to be a true anti-Diabetic therapy and, as I mentioned to you, the screening value for Hemoglobin A1c had been 7.5% in each group, and at baseline after 4 weeks of dietary therapy, exercise therapy, the drop in Hemoglobin A1c was about 0.2 to 0.3 because you can see the baseline values are now 7.2 to 7.3 across the 3 treatment groups.

And if we then look at what an additional year of therapy does, in the placebo patients there is actually, despite continued dietary intervention, actually loss of some of that small amount of gain and that they go back up to 7.3, whereas in the Rimonabant

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

20mg group we have an additional 0.6 fall in Hemoglobin A1c. So this represents a change from screening which is approaching the 1% range. Compared to placebo this is a difference of 0.7% in terms of Hemoglobin A1c which is well in the range of what is seen with currently approved anti-Diabetic therapies.

If we go to the next slide, the question is the appropriateness and the efficacy of Rimonabant on top of the 2 most commonly prescribed or classes of oral medication. And you can see that the placebo subtracted result of 0.7% is achieved both on top of Metformin and on top of Sulfonylurea, indicating that which are clearly the 2 major first-line therapies. So add-on is equally effective in both of the major first-line therapies for Type 2 Diabetes.

We go to the next slide. The important physicians recognize that what is probably the best assessment of an anti-Diabetic therapy is actually not the absolute fall on Hemoglobin A1c, but the percentage of patients who can actually achieve goal. Why do I say that? Well, the fall in Hemoglobin A1c that you see with any given therapy is largely a function of how high the Hemoglobin A1c is to begin with. And if you go back and look at product labels for marketed products, the older the product the more you may see a Hemoglobin A1c fall because Diabetes was less well-controlled in the past and so patients entering the study were less well-controlled. And so the absolute fall is a little bit [artefactual] depending on where you started.

We started in this study with Hemoglobin A1c at the -- at baseline of 7.2 to 7.3, which means that these patients were very well-controlled to begin with after the 4 week run-in period. And so the -- that's why I'm focusing on the percentage of patients who achieved the Hemoglobin A1c goal of 6.5%, which is actually more stringent than the current ADA recommendation, but it is the recommendation which is used by the International Diabetes Federation and the American Association of Clinical Endocrinology. So it's a very aggressive goal, and there was a doubling of the percentage of patients who could achieve that goal. If we use the ADA goal, it's more than a half of - which is 7.0, it's more than half of the patients who were above 7, achieved that goal at the end of the year compared to 26% in the placebo group. 52.7 versus 26. So whether you use the ADA goal, whether you're on this side of the Atlantic and you wanted to use the ADA goal or if you want to use the IDF and European goal, it's still a doubling of that percentage and between 40 and 52% achieving it.

If we go to the next slide, which harkens back to that -- one of the first slides I showed you indicating that Rimonabant mechanism of action includes both targets that permit people to lose weight, but also direct metabolic targets in the important organs that control glucose and lipid metabolism. We therefore looked at the percentage for the Hemoglobin A1c fall which was due to the effect of weight loss, and that which could not be attributable to weight loss alone representing the direct pharmacologic effect of some of the unique profile in Rimonabant. And as you can see on this slide, more than half of the Hemoglobin A1c effect was indeed seen to be not attributable to weight loss and an independent pharmacologic effect of CB1-Receptor Blockade.

Going to the -- so those are the summary of the Hemoglobin A1c changes. Now looking at the other metabolic syndrome components which have been described in non-Diabetic patients, we see very much the same profile in the Diabetic patients. A reduction -- an increase in HDL-cholesterol of about 15% from baseline in 20mg, compared to 7% in the placebo group for a placebo subtracted difference of 8.5% in the ITT population.

A nice triglyceride effect on the next slide of an increase in triglyceride of 7.3 in the placebo, compared to a decrease of 9% in the Rimonabant 20mg for the placebo subtracted difference of 15%. Again in the range of what you see for drugs that are approved for the treatment of hypertriglyceridemia.

An interesting finding is shown in the next slide, which is a small but clinically and statistically significant improvement in systolic blood pressure, similar trend in diastolic blood pressure with a placebo subtracted difference of more than 2mm of mercury, which would be in the range that would show, for example, statistically significant reduction in the incidence of stroke in Diabetic patients.

If we look then, with the effect on triglyceride blood pressure, fasting glucose, waist circumference, on the next slide we find a more than twofold improvement in the reduction in the prevalence of metabolic syndrome by the ATP III criteria in the 20mg group versus placebo.

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

The next slide, number 23, is designed to reinforce the consistency of effect across the entire scope of what we would see as a metabolic target population covered in the 4 RIO studies, with consistent improvements in the 4 major components of the metabolic syndrome, waist circumference, HDL-cholesterol, triglyceride. And the results in the blood pressure they show a parallel -- they show a similar trend, but in the patients who are most metabolically affected -- that is the patients with dyslipidemia in the RIO-Lipids study and in the patients who had Diabetes in the RIO-Diabetes study, those are at highest risk - we see the best additional benefit on blood pressure which we think will be very important in looking, for example, in overall cardio metabolic risk and cardiovascular outcomes.

Moving now to safety. The -- what the bottom line I think is that the RIO-Diabetes study extends the reassuring safety and tolerability profile, which has been seen in non-Diabetic individuals into another 'at-risk' population, which is a somewhat vulnerable population, and what we see are a very similar overall pattern of tolerability.

The adverse events are listed on slide 25. The ones which occur with greater than 5% frequency, and again we see nausea, we see some dizziness which is almost all of that is transient and mild. Often times -- 1k, one episode of nausea, one episode of dizziness. Vomiting is again shows [up to as it has been before], usually is a, again, transient self-limited. Hypoglycemia, I'll come back and talk about, and anxiety just makes it into the 5% range. In the previous studies it had been just below 5%. So again a very similar pattern of adverse events.

Just to dwell on the hypoglycemia, in almost every Diabetes study that's performed, the attainment of good Diabetes control close to normal, is the major factor which drives the frequency of hypoglycemia. So Diabetes investigators would be quite surprised if there were not an increased frequency of hypoglycemia in patients with Diabetes on background therapy who were being brought to so close to the treatment goal. And so this is an expected event and not at all surprising. In fact it would be anticipated in a Diabetes study.

Moving to the next slide, the overall safety, you've seen this -- you've certainly seen this before, and again it's quite similar. Subjects with any adverse event in the 80% range with little change among the 3 treatment groups. Serious adverse events again in a similar range across the treatment groups, and discontinuations due to adverse events are higher in the 20mg group compared to placebo. Once again, the 15% number is virtually identical to what has been seen in previous trials in non-Diabetic subjects.

And I'll reinforce that on the next slide. Now that we have completed the RIO program we were very happy to show the overall, the overall treatment tolerability program for the pooled studies. And what you see here, again adverse events in the first year, around 80%. Across the 3 groups, serious adverse events showing relatively similar pattern across the groups. An increased frequency of discontinuations due to adverse events in the Rimonabant 20mg group, looking at the 1 year data, but when you look at the 2 year data you find the pattern which is virtually identical to placebo, both for adverse events, serious adverse events and discontinuation due to adverse events. So again the RIO-diabetes program simply extends this tolerability program into a new population.

To summarize the results then, in patients with Type 2 Diabetes who were quite well-controlled at baseline after a 4 week diet run-in period, there was a further reduction compared to placebo of 0.7% in Hemoglobin A1c, which would calculate out to a 25% decrease in the risk of Diabetic complications. 43% of the patients achieved a very stringent goal, more stringent than the ADA goal by achieving the international goal of 6.5%. More than half of that effect was independent of the weight loss and represents the unique pharmacology of CB1-receptor Blockade. And the improvements in the other metabolic parameters were consistent with the other RIO studies. 15% increase in HDL, 10% decrease in triglyceride, reductions in waist circumference in metabolic syndrome prevalence, and an overall tolerability profile which was reassuring.

And so the conclusions that Professor Scheen drew were that Rimonabant is the first selective CB1-Blocker study for the treatment of Type 2 Diabetes, and related metabolic disorders it achieved clinically significant improvements in HbA1c, lipids and blood pressure with a concomitant of substantial reduction in body weight, and it thereby, in his estimation, constituted a new

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

approach to the management of Type 2 Diabetes, addressing multiple cardio metabolic risk factors commonly observed in these patients.

So that's a summary of the new data and I think I can--

Felix Lauscher - Sanofi-Aventis - Director, North American IR

Thank you very much, Doug, and now we may want to ask the Operator if you could please open the lines for questions

QUESTIONS AND ANSWERS

Operator

Thank you. [OPERATOR INSTRUCTIONS]. We will now take the first question from Andrew Brown of Morgan Stanley. Please go ahead.

Andrew Brown - Morgan Stanley - Analyst

Good morning. 3 questions if I may. First related to the Regulatory pathway for Diabetes indication for Acomplia. This trial is a pretty limited sub-group for the Diabetic patients. My assumption is that you're going to wait to augment that data set with additional clinical trials before asking for primary indication for Diabetes. If you could say a few other words on that?

Second, your press release comments quite extensively on the weight-independent effects of Acomplia. Could you outline that statistical process by which you demonstrate this, and again comment on how the Regulators will view that? I understand there's a number of ways to try and demonstrate independence statistically.

And then finally could you just explain the -- whether there was any titration of either the Sulfonylureas or Metformin background therapy with these patients if they fail to get to goal? Or they were left untouched until the end of the study?

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Okay, 3 good questions. Regulatory pathway, I think I'll start off by saying that it's obviously not our policy to go into details in Regulatory issues which are currently being discussed with Health Authorities. So, and I'm sure that you all understand and fully anticipated that would be my answer. However, I think -- and I've said this before and these results just reinforce this -- Rimnabant doesn't fit any 1 of the buckets of an anti-Diabetic, and anti-Obesity. It really is a different profile, a different cardio metabolic profile.

The data, I think, are quite impressive in the Type 2 Diabetes in terms of the range of Hemoglobin A1c improvement that we see. We, as you know - and I said before - our goal and the goal of Health Authorities is to create a label that permits physicians to target this drug to people where the benefit risk is most positive, and these data would suggest that in the patients that we studied on this background therapy, there is a substantial benefit. The -- one would predict a substantial long-term clinical benefit, given the impact on these cardio metabolic risk factors.

So I think that our discussions with the -- with Health Authorities - will certainly move in the direction of capturing this appropriately and prominently in our label. And I think the exact details of that remain to be seen, and obviously we're going to discuss that on both sides of the Atlantic Ocean.

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

The question of weight-independent effects. This is a fairly robust analysis which has been looked at not just in 1 way but in multiple ways. As you all know, when you design a study and a statistical analysis plan, you must commit to 1 form of analysis pre-specified before you break the data, before you break the study code and so forth, and so we did submit an analysis which is multiple with logistical regression analysis on the 12 month time-point. That was submitted to the Agency. They understand that. That was our primary analysis, and all the results that we have shown are based on that primary analysis.

However, we have done sensitivity analyses, both looking at categorical weight loss, weight gain buckets if you will. We have also, in collaboration with some well-known outside statisticians, done repeated measures analysis, and whichever way you look at it you come up with a -- with essentially the same conclusion, and so we think that this is a robust statistical conclusion.

Your last question dealt with the question of titration. The study protocol recommended that dosages not be changed unless there was a compelling need to change the dose in the interests of patient -- the patient care. About 3 -- about almost 80% of the patients did not change their dose. But if you look in the different sub-groups you find that there was more upward adjustment in the placebo patients, and there was more downward adjustment in the Rimonabant 20mg group. So titration, it was not a forced titration, but whatever dosage adjustment did occur would have led to an underestimation of the true Hemoglobin A1c effect of Rimonabant, so I thank you for asking that question.

Andrew Brown - Morgan Stanley - Analyst

Thank you.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

In fact these effects was even totally statistically spectacularly significant for 20mg.

Andrew Brown - Morgan Stanley - Analyst

And just a final point was just commenting on what other trials you have ongoing or planned within Diabetics in combination with Insulin or with multiple oral hypoglycemia agents.

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Sure. We are looking to move forward and study the use of Rimonabant as primary therapy and in combination with Insulin and other drugs that have not been covered in the current RIO-Diabetes study.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Just yes, I just have some -- just to add something. The purpose of Rimonabant, as I say, is not to be an add-on therapy for a -- on a specific drug. But in fact just for technical reason, because at the beginning we do not have good understanding of the effect of Rimonabant in the Diabetic population that we've picked up this population. When you're looking at the profile of the drug, it is relatively obvious that the earlier you are taking the drug the better you are. So the question is not too much on top of Insulin, except that we may have a good effect on weight. The question is much more what are we doing in first-line therapy or even what are we doing in prevention of Diabetes?

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

And I think it's fair to quote Professor Scheen, when he was asked this question he said, yes we've only studied it on top of Metformin and Sulfonylurea. But as a Diabetologist, he has never seen a drug that has this kind of profile in the presence of Metformin and Sulfonylurea that would not have a general benefit in the treatment of any patient with Diabetes, and potentially in the prevention of Diabetes. So that was the comment that he made after his late-presentation.

Andrew Brown - Morgan Stanley - Analyst

Thank you.

Operator

We will now take the next question from David Beadle of Sanofi. Please go ahead.

David Beadle - UBS - Analyst

David Beadle at UBS actually. As far as I'm aware I'm not working at Sanofi at the moment. I just wanted to follow up on 1 of Andrew's questions about the sort of reduction in HbA1c and the effect on lipids regardless of weight loss, and you mentioned that you've got a sort of bucket of patients. So I just wondered did the statistical analysis that you'd originally done include some of the big Type 2 Diabetes studies, the sort of data that was seen from those studies like the U.K. PDS or the DCCT?

And then secondly, on the hypoglycemia, could you just put that in the context of what you'd expect to see as elevation in hypoglycemia with the standard oral Diabetes agents as a sort of placebo basis? Just to give us an idea as to whether that is the sort of impact that you'd expect to see for roughly a 0.7% reduction in HbA1c.

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Yes, well at first I think maybe I wasn't clear in my description of the multiple regression analysis, or the statistical analysis that we did. This was not done as a meta analysis comparing our results with other trials. This was a statistical analysis within the study itself in which 1 looks at the 3 treatment groups and looks at the relationship between change in body weight and change in whichever parameter you're looking at for the 3 treatment groups. 20mg -- actually it was done for the 2 treatment groups -- placebo and 20mg. And so it is an internal statistical analysis and what it shows is that for any level of weight loss or weight gain there was a greater benefit in the Rimonabant 20mg group compared to placebo. So this was not a statistical analysis based on external data, it was a statistical analysis based on the internal trial data.

So did that answer your first question?

David Beadle - UBS - Analyst

Yes thanks.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Also I would like to add something on the weight loss. If you have a drug starting first inhibitors and with additional weight loss everybody will be very happy to have a drug with an effect on Diabetes with weight loss. It's just because we also have it the other way, [indiscernible] that in fact people asking this kind -- these kind of questions, because at the end what do you want? You want a drug which is active inhibitors and you want a drug which is reducing the weight. So the fact that it is

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

dependent, or independent, we will have some very strong data for the independent per se. But I think it's just a kind of futile question. The point is you want a drug which is active inhibitors with weight reduction. This is what we have.

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

The second question was to try to put this in the framework of the type of -- the rate of hypoglycemia which you would achieve. If you look at the DCCT for Type 1 Diabetes, if you look at the U.K. PDS in patients on Metformin and Sulfonylurea or the combination of Metformin and Sulfonylurea, we are exactly in the ballpark of what you would expect to see in a newly, a relatively short duration Type 2 Diabetic patient achieving a Hemoglobin A1c down at the level of nearly 6.5%.

Now it also depends on the type of drug that you're using, and so as you would -- as you probably all know, Metformin alone can produce hypoglycemia in mono-therapy, but it is less common to find hypoglycemia with Metformin therapy than with a Sulfonylurea which is more likely to produce hypoglycemia. And we see exactly the same thing in our study with the rate of hypoglycemia being about twice as great on a background of Sulfonylurea compared to a background of Metformin.

So it basically says that the hypoglycemia which occurs, particularly in the Sulfonylurea group, is largely a function of the Sulfonylurea rather than the -- any specific effect of Rimonabant. And since Rimonabant would primarily work by improving Insulin sensitivity not by augmenting Insulin secretion, it would make it much less likely to cause hypoglycemia than, say, either Insulin itself or a drug like a Sulfonylurea that stimulates Insulin secretion. So the pattern of hypoglycemia both numerically and qualitatively is exactly what would be anticipated.

David Beadle - UBS - Analyst

Thank you.

Operator

We will now take our next question from Ben Yeoh of Williams de Broe. Please go ahead.

Ben Yeoh - Williams de Broe - Analyst

Hello, I had a couple of questions. 1 is in terms again of the Regulatory process a little bit. I was just wondering whether you can confirm on the priority review whether you've heard from the FDA yet? I was hearing that perhaps he might not have actually applied for a priority review.

And also from what exact indications are you going for first, as I guess a follow-on from where you'll be on the how you're applying for the Diabetes Type indication?

And secondly, just on a little bit of the data on the blood pressure and weight-independent effects, there was a study in hypertension which suggested that for each kilogram of weight loss you should be losing about 4 on the systolic, and you only lost about 1. So I was just wondering whether actually that there might be some effect of Acompla which is increasing blood pressure working against what you're seeing in terms of weight loss? I was just wondering how the more detailed stats that you've done weigh out on that?

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Okay, those are good questions. In terms of the Regulatory question that you ask, again I'm not going to -- I'm not at liberty to go into details of our filing and our discussion with Health Authorities. At the moment all I can say is that we will be somewhere within the [produfa] time-frame and I can't be any more specific than that at this point.

I'm not going to describe the exact indications because we don't know the exact indications. We're still in discussions with Health Authorities. We think that -- and again, this is a unique profile. It's not going to necessarily fit in any specific bucket, and we're trying to be creative, working clearly with the Health Authorities to come up with the best label to help physicians understand how to use this drug. And I think that's -- you'll have to stay tuned and we'll update you when we have information, but at the moment we don't.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Yes, Doug for the blood pressure I think I can take the question. For a new active effect you know that we are also developing the drug in [talking physician], and you know that I think 1 of the nice aspect of the drugs is when -- it is that when you have a BMI which is below 25, you have roughly no effect on weight. So if we had a direct effect on blood pressure, a negative 1, so if we increase the blood pressure we should have observed in fact in this population an increase of blood pressure because we have no effect on weight. And in fact it's not the case, we are totally neutral on blood pressure in this population. And again I bring it to your attention of the biggest loss of weight versus the weight of a bigger loss of blood pressure versus weight loss, in fact when we are matching with placebo in our study, we are totally matching the result of placebo with 20mg.

So we do not have a direct effect on blood pressure with Rimonabant. We have just an indirect effect on weight loss. Again a direct effect on blood pressure by increasing the blood pressure. It is not the case in the smoking population.

Ben Yeoh - Williams de Broe - Analyst

Okay.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Just an effect on the smokeless.

Ben Yeoh - Williams de Broe - Analyst

Just to reiterate, you're saying there's definitely no positive effect on blood pressure -- that is --

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Clearly, you know in the smoking population below 25 of BMI well, we have absolutely no effect on weight.

Ben Yeoh - Williams de Broe - Analyst

Okay.

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

This population we have no effect on systolic blood pressure or in fact on just blood pressure item.

Ben Yeoh - Williams de Broe - Analyst

Great. And just quickly in terms of the priority review, you would tell us if you did receive one?

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

I think the question about when we update on our filing, you know, things will move along. They'll be posted on the FDA website and, so at that point, we'll have more to say, but at this point we don't have more to say.

Can I go back to the question of blood pressure because there is a point that you're missing here. Most -- the data that you quote is essentially changed from base line when you reduce weight by dietary intervention, exercise and so forth. And we need to remember that during the 4 week run-in period, where there was almost, on average, a 2 kilogram weight loss, we do see a significant fall in blood pressure in all of the studies.

And so that, part of the reason that -- and blood pressure falls, in many studies, fairly early when you do a diet and exercise lifestyle management. So that's already occurred outside of the randomized portion of the trial. It's not captured in the placebo difference. And so what essentially you see is that if there were a positive effect on blood pressure, you would expect to see loss of some of the lowering of blood pressure that was induced early on by a change in lifestyle, and we see absolutely no evidence of that. So it re-enforces what Marc said, taking from the smoking cessation studies.

Unidentified Participant

Okay, thank you.

Operator

Our next question comes from Graham Parry of Merrill Lynch. Please go ahead.

Graham Parry - Merrill Lynch - Analyst

Hi, good afternoon. I've got a few questions actually. Just looking at the fact that you've seen the 0.7% reduction in HbA1c in patients who are already quite well controlled. It seems feasible that the reductions would be higher if you were to take an untreated patient population. So, I guess, the first question is, is that a study that you would look at planning, and with perhaps the aim of going for a diabetes or treatment -- treatment of diabetes label.

And secondly on that, do you have any stratification from this study of what the HbA1c reductions versus placebo were in let's say, a stratified group of patients with higher base line HbA1c in the study, whether that was greater than the 0.7%?

The second thing is actually on concomitant therapy. You obviously didn't have TZDs or insulin in the study. Is that likely label limiting in any way? So could you, in any way, be [contouring] cases in patients who are on insulin or TZDs and are there any potential interaction issues there that you are already aware of?

FINAL TRANSCRIPT

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

And then the final question was just on the safety database. I see you had about 688 patients, I think it was, for the 2 year safety database, for the final safety analysis for the pooled studies. Could you just confirm that's the number of patients completing the 2 years rather than starting the 2 years?

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Okay. Those are good points. Let me address them 1 at a time. Obviously, as I said, the higher the hemoglobin A1c, the more that you would expect to see a fall. Patients with -- newly diagnosed patients do tend to come in with a higher hemoglobin A1c, and so we would expect a fall that might be greater than we've seen in this study, on top of metformin and sulfonylurea.

And if you look at the stratification, which is I think the most salient point, if you look at patients who had a hemoglobin A1c greater than 8 at base line, you see a placebo subtracted difference of 1.1% hemoglobin A1c. That's the ITT last observation carried forward. So, it's exactly what you would predict. It does suggest that, in other settings, we might see even greater hemoglobin A1c changes, and we surpass the 1% mark, if you look at patients whose base line was greater than 8%. And the P value on that is, again, 0.001.

So all of the issues that you raise in your question we can answer quite positively and, so, we're quite optimistic. We don't foresee any type of interaction with either TZDs or insulin, except to say that we may have -- we would anticipate to have a very beneficial effect on the weight gain, which is associated with both TZDs and insulin, which in many cases becomes limiting in how well you can use them in the clinic.

Graham Parry - Merrill Lynch - Analyst

Okay, and on the safety database?

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

The safety database -- sorry about that. Your question was, yes, we have the numbers that are quoted are those who completed the second year in the year 2 life of the clinic data.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Although I think that it is, people that were included at the beginning, we were a little bit less than 1,000 for the patients who completed, in fact, the real program on Rimonabant.

Graham Parry - Merrill Lynch - Analyst

So, sorry, the 688 refers to the number of patients who started the second year therapy on 20mg, and the 1,000 patients would be patients at 5mg and 20mg?

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

And 20mg at 2 years, yes.

Graham Parry - Merrill Lynch - Analyst

Okay. So, and how many patients at 20mg completing 2 years?

FINAL TRANSCRIPT

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

I don't know. I think it will be roughly equivalent, except that it was a little bit less to a 1,000 on 20mg, because the people were feeling the benefit of the drugs. I will think a little bit more on 20mg than on 5mg.

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

I think that would come out to be something like, what, 500 at the --

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Yes, I think 500 and 500, or 480 and 520, something like that. But it's close to 500, 500 for the 2 groups.

Graham Parry - Merrill Lynch - Analyst

Okay, that's great. Thanks very much.

Operator

We will now take our next question from Sebastian Berthon of Exane. Please go ahead.

Sebastian Berthon - Exane PNB Paribas - Analyst

Yes, hello gentlemen. I have 1 question on the HbA1c regards reduction. Could you give us a sense of how it goes over time during the year? If you've reached a plateau somewhere, or is it a re-bounce somewhere?

And the other question on the side effect profile. Could you give us any sense of any depressive moods you've seen in small numbers, or any deaths in the RIO-Diabetes trial?

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Okay. So, the first question is the hemoglobin A1c effects. If you look at the time course, basically what we see is about 0.7% placebo subtracted result, which is achieved at month 36, and is maintained at month 52. So the drug effect looks about -- it looks like it stabilized between month 36 and month 52, and we obviously don't have data that goes beyond that.

With regard to side effects, we have, again, a very similar profile compared to what we have seen before in terms of a numerical difference in discontinuations, due to mood disorders. So again, if we look at reasons for discontinuation in the 1 year treatment period, we are in depressive disorders, and mood alterations with depressive symptoms were up a little bit below 3%, which is exactly what we had seen in the previous studies, compared to about half that in the patients who were on placebo. So again, no new news here. Exactly what we've seen in the other studies.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

And just to add something to that. [indiscernible] is a metabolic effect of [Rimonabant]. You know that we have 2 years data. So we do not have per se a big deposit of hemoglobin that [indiscernible] is affecting glucose.

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

And in the 2 year data, in fact, we have a continuous improvement. It is true also for each year with a continuous improvement of these parameters. So we may expect, in fact, that the benefit [indiscernible] HbA1c at the minimum will be continued for 7 years.

Sebastian Berthon - *Exane PNB Paribas - Analyst*

Okay, thank you.

Operator

Our next question comes from Alexandra Hauber of Bear Stearns. Please go ahead.

Alexandra Hauber - *Bear Stearns - Analyst*

Yes, good afternoon gentlemen. I have 2 questions. Just 1 is coming back on the weight independent effect. Could you elaborate on how the -- attack mechanism causes that weight independent effect, and particularly with a view on what clinical proofs you have been able to establish for such a mechanism?

And then the second question on the side effect. You just mentioned the number, but I think for the previous studies you have actually disclosed how many of the patients have discontinued due to serious side effects, and discontinued due to psychiatric disorders. And I was just wondering what made these patients dropping out? Was it just patient choice, or was there some sort of trigger points which you have designed, for making sure they leave the trial at a certain point?

Douglas Greene - *Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs*

Okay. I could probably give you about a 2 hour lecture on the weight independent effects, which is, I am sure, not what you want. Let me put it to you this way. That basic science research, both inside and outside the Company, has demonstrated that, at the level of the fat cell, and that blockade of the CB1 receptor in fat cells, increases the gene expression and the secretion of adiponectin, which is the same downstream mechanism that are activated by the glitizones, the Ppar gamma activators. So, Ppar gammas work in the fat cell. They increase adiponectin, which is probably responsible for many of their beneficial effects.

Unfortunately, they also cause the fat cell to grow and get larger and multiply, which is their adverse effects. We don't cause the fat cell to get larger and so forth, but we do cause -- in fact, we have the opposite effect. But, nevertheless, we do cause the fat cell to increase adiponectin, and we think that is a major cause of the improvement in HDL and also a component of insulin sensitivity.

The second point, where CB1 receptor blockade works is that there's a switch in the liver that controls the synthesis of fatty acids and triglycerides, and switches the liver from a fat burning organ to a fat synthesizing organ. CB1 agonists increase that switch. They take the switch and move it from fat burning to fat making, and by blocking that receptor we take the liver and switch it back from an organ that synthesizes fat to an organ that burns fat. And again, that's an independent, direct effect on the liver, independent of any change in body weight.

So that's the simple version of the basic science.

The question about drop outs and trigger points, you are exactly correct, particularly with regard to mood alterations. We had, from the very beginning of the RIO program, we had done specific assessments of mood in these patients, and so, if anything, this leads to an over-reporting of mood alterations in the trial as a whole. These patients received a questionnaire on anxiety and depression at every -- periodically at their visits during the clinic. They knew they were going to be questioned about that,

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

so they were clearly keenly aware that this was something that the sponsor and the investigators were interested in, and so this would lead them to be very forthright and, perhaps, over-report symptoms of mood alterations.

That score, by the way, called the HAD score – the Hospital Anxiety Depression Score – didn't show any deleterious effect over time, or in the 2 treatment groups. But, it did lead to prompted referrals to psychiatrists if the score achieved a certain threshold, and if the score achieved a certain threshold, then the patients were referred to a psychiatrist. And if the psychiatrist decided to try an anti-depressant to see if he could help the patient, that was a mandatory discontinuation.

And the reason for that is, as you know, anti-depressants affect body weight. Body weight change was the primary outcome analysis, and so it would have confounded the analysis, if those patients remained in the study. So, yes there was a trigger point. Yes there was probably a bias to over-report and yes there were mandatory discontinuations if the patient was started on a trial on an anti-depressant.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

And just to complete the result of survey, in fact there was not so many drop out due to depression. In fact, the different reasons for depression were randomly scattered between a [indiscernible] disorder, a little bit of anxiety and a little bit of depression. And so that was not the main reason for drop out.

Alexandra Hauber - Bear Stearns - Analyst

Just 2 follow up questions on that point. So, basically if the hospital anxiety depression score triggered the referral to the psychiatrist, how often were these patients then asked during the study to fill out that questionnaire? That's question number 1.

And then you specified a trigger point for depression, but anxiety would have been the same thing. As soon as the psychiatrist then would recommend medication, that's the time to take out patients -- discontinue patients due to anxiety?

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Okay, let me answer your second question first. No, that if a patient was put on an anxiolytic, that wasn't a mandatory drop out, because anxiolytics tend not to affect body weight.

I think, and perhaps somebody else can correct me, but I believe that these were done at almost every visit.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

It was done every 3 months.

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Every 3 months. Okay. Every third visit. Thanks Marc.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

Which is already a lot.

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Alexandra Hauber - *Bear Stearns - Analyst*

Okay, thank you.

Operator

Our next question comes from Ramish Rajinturn of UBS. Please go ahead.

Ramish Rajinturn - *UBS - Analyst*

Thank you gentlemen, but my question has just been answered. Thank you.

Operator

Thank you. Our next question comes from Michael Leacock of Nomura. Please go ahead.

Michael Leacock - *Nomura Securities - Analyst*

Thank you. Just a couple of questions if I may. On the safety issue, you mention an 8% of patients with a serious adverse event. Could you just talk a little bit about what those adverse events were?

And also, could you talk -- you said 15% discontinued due to an adverse event. Could you just highlight what the primary reason for those discontinuations were?

And if I may also ask, you said the trigger point was an HAD score. What was the score that was the trigger point?

Douglas Greene - *Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs*

Okay. Let me start with your third question. The HAD score, the average when the patients came in the study was about 3. A HAD score of 11 was the trigger point for a referral.

Your question about the discontinuations due to adverse events. The numbers that I gave you were for depressive disorders 1.9%, mood alterations 1%, anxiety 1%, dizziness 0.7%, nausea 1.4%, so forth and so on. The list is very long and very varied. But those are the major ones.

With regard to your question about serious adverse events, generally the SAEs were widely scattered. I don't have those figures in front of me at the moment. They were widely scattered and essentially were exactly what you would expect in a patient population at high risk type 2 diabetes. I don't have the full list of SAEs, but they were mostly disease related.

Michael Leacock - *Nomura Securities - Analyst*

Were there any deaths in the study?

Douglas Greene - *Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs*

There were some deaths.

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

It is on the slide that we have [balanced] result between the different groups. So I think for the world program there were 4 deaths on placebo, 3 deaths on 5mg, 4 deaths on 20mg, but you have to remember that it's totally balanced. I think we have 1,600 patients on placebo and 2,500 on Rimonabant. But I will say that the number of deaths is balanced and, in fact, I think we have 3 deaths in this study on 20mg. But no-one was considered as related to the product by [the executors]. For example, we have the passenger in a car accident. Something like this.

Michael Leacock - Nomura Securities - Analyst

Okay, gentlemen. Thank you very much.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

You're welcome.

Unidentified Corporate Representative

Operator, we take 2 last questions please.

Operator

Thank you. We will now take our next question from Mark Purcell of Deutsche Bank. Please go ahead.

Mark Purcell - Deutsche Bank - Analyst

Yes, good afternoon, good morning everyone. Just a couple of quick questions. The first one - are there any drug interactions between accomptia and SUs in that form, just in respect to the hypoglycemia -- increase in hypoglycemia you saw?

The second question is, in terms of mortality and morbidity, you described, obviously, the HbA1c impact in terms of the impact on diabetic complications. Could you give us any feel for how the other benefits translate into mortality and morbidity benefits?

And the last question is, if you look at Xenical, or the reduction in HbA1c from base line is about 0.5 percentage points, roughly half of it is weight dependent, roughly half is weight independent. Could you just draw some parallels for us between Xenical and accomptia in terms of the overall effect, the likely approach with regulators, and your future action going forward? Clearly they went for a diabetes prevention study, which I believe you are starting at the moment. What other differences you feel you are going to pursue relative to Xenical? What lessons you've learned relative to Xenical on your product compound so far?

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Okay. The first question was the question about interactions with sulfonylureas and metformin. From a pharmacokinetic perspective we would expect no basis for interactions. As you know, as we've talked about before, the Rimonabant is metabolized primarily in the liver by a variety of different enzymes. It doesn't induce, and doesn't inhibit any of the drug metabolizing enzymes. So, we see no reason for a pharmacokinetic interaction.

As I indicated previously, sulfonylureas are more prone to produce hypoglycemia, because the way they work is that insulin secretion is stimulated pharmacologically. Physiologically, when your blood glucose gets low, the insulin secreting machinery

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

turns off to try to protect against hypoglycemia. Sulfonylureas override that, so you would expect that with any therapy, on top of sulfonylureas, there would be a slight increase in the rate of hypoglycemia, compared to being on top of a drug like metformin.

And, as I said, the rate of hypocalcaemia reported as an adverse event in Rimonabant versus placebo, the absolute rate was higher in the sulfonylurea background group compared to the metformin group, which is exactly what you would expect to see, driven primarily in both cases by the fact that you're getting closer to the threshold of hypoglycemia, because the patients are getting in better control. So, whenever you do combination therapy, you would expect more hypoglycemia on top of sulfonylurea compared to metformin. That's exactly what we saw.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

And it was also very mild and moderate events, not [indiscernible].

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Your question about mortality, morbidity. The improvement in hemoglobin A1c that we see would translate into, perhaps, a calculated 25% improvement in the risk for micro-vascular complications.

The question about what does this degree of HDL lowering, and this degree of increase in -- I'm sorry HDL raising, and triglyceride lowering, perhaps the only place to look at that would be in the diabetes portion of the VA-HIT study, which demonstrated, if I remember correctly, about a 30% risk reduction for CV events. But, again, that's a different population, different study group, so it's hard to really extrapolate that.

If you go back and look at the heart protection study, what you basically see is that, even on top of a statin, in the heart protection study, a diabetic treated with a statin had a greater cardiovascular risk than a non-diabetic who had had -- who wasn't treated with a statin. And so the concept is that we would basically reduce that residual risk down to the level of a non-diabetic, if -- particularly if it were used in combination with other risk factor reducers.

You're talking about in the HPS, a 10 year prediction of 60% of those people would have a cardiovascular event, and compared to about 30% in a non-diabetic individual. And so if, as we believe, we are addressing the major non-LDL component of cardiovascular risk in these patients, you're looking at a considerable reduction.

That is a whole series of extrapolations, and obviously the only way we'll know that, is with the studies underway, which are a cardiovascular outcome study, looking at anatomical atherosclerosis with an IVIS study. But the potential is really quite extraordinary.

Mark Purcell - Deutsche Bank - Analyst

Sure. And in terms of lessons learned from Xenical, you had a 0.5% unit reduction at a base line of around about 9. 50% of it was weight independent, and yet they didn't get a significant label with which to promote. Any comments on that please?

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

I think we have a significant development for Rimonabant. I think we have, at least in terms of metabolic [indiscernible] specific profile. So let's look at Rimonabant, and if we have questions then you can ask the company making Xenical. I think it is better this way.

FINAL TRANSCRIPT

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

Mark Purcell - Deutsche Bank - Analyst

Okay. And just in terms of -- we're going to get a lot of outcome data on Avandia and the sensitizers going forward. When were going to start a sensitizer combination study, given this drug seems to have, as you say, clearly a very positive benefit in the earliest treated patients?

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

I don't think we can talk about the specific time frame. It's clearly something that's in our scope, and so forth.

Mark Purcell - Deutsche Bank - Analyst

Okay.

Unidentified Corporate Representative

Operator, 1 last question please.

Operator

Thank you. We will now take our final question from Julia [Kennarick] of Lehman Brothers. Please go ahead.

Julia Kennarick - Lehman Brothers - Analyst

Hi, and thank you for taking my question. I just have 1 question remaining. First of all, do you plan to show any follow up data from RIO-Diabetes? I understand this is a 1 year study, but we were wondering if there would be anything else?

And also, were patients immediately taken off the drug when the trial finished?

Actually, I've got 1 further question, which was, how easy was it to maintain the calorie controlled diet for these patients? Can you talk a little bit about the technicalities and the protocol of that? Thank you very much.

Douglas Greene - Sanofi-Aventis - VP Corporate Medical & Regulatory Affairs

Sure. We don't have a follow up in all of the RIO studies. When the study was finished the patients were discontinued.

The question of long term -- understanding long term use of the drug was pre-designed in the second year of the RIO North America and RIO Europe studies, and Marc had already alluded to the fact that we show, in those studies, prolongation and durability of the effect. We don't have specific follow up in the RIO-Diabetes study, and they were discontinued.

The question about how easy is it to maintain caloric control, I think that we don't have, at this point, a detailed assessment of exactly what patients were eating. I think the general feeling of the investigators is that it's very difficult to maintain patients on lifestyle and caloric restriction. Someone has calculated that if the patients were actually maintaining a 600 kilo-calorie per day deficit in their caloric intake, they would have had massive degrees of weight loss and so we know that compliance is very difficult to achieve with diet and exercise. That's why people are looking for pharmacologic solutions.

And so we can say with some degree of assurance that the compliance was, despite the fact that patients were seen by a dietician at each visit, they were encouraged to exercise, this is real life and the study was designed to mimic real life, with standard of

FINAL TRANSCRIPT

Jun. 13. 2005 / 11:30AM, SNY - Sanofi-Aventis Conference Call on Results on RIO-Diabetes

care. So the standard of care was equivalent to what you would expect in the best clinical practice, but you are quite right, the compliance was probably not very good.

Marc Cluzel - Sanofi-Aventis - VP International Development, Scientific & Medical Affairs

If you are looking to the result of placebo, you will see that the result achieved on placebo in RIO is quite good result. And in fact in most of our study we are missing the [smile] [indiscernible]. The covering up at the end of the treatment just because we have a strong program with [indiscernible]. So the result on placebo are quite good.

Julia Kennarick - Lehman Brothers - Analyst

Okay, thank you.

Unidentified Corporate Representative

Okay, thank you very much Doug. Thanks to Marc and Sanjay in Paris. We also want to thank all participants for your participation here, and please don't hesitate to call the Investor Relations department direct if you have any further questions.

Operator

Ladies and gentlemen, that will conclude today's conference call. Thank you for your participation. You may now disconnect.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2005, Thomson Financial. All Rights Reserved.

Exhibit I



RIMONABANT ACCEPTED FOR FILING BY THE FDA

Paris, France - June 23, 2005 - Sanofi-aventis announced today that the United States Food and Drug Administration (FDA) has accepted for filing the company's New Drug Application (NDA) for rimonabant, the first agent in a new therapeutic class known as selective cannabinoid type 1 (CB1) blockers.

Rimonabant, discovered and developed by sanofi-aventis, is thought to represent a new approach for the comprehensive management of cardiovascular risk factors. The compound has been studied to date in over 6,500 overweight and obese adults for up to 2 years.

Despite therapeutic advances in recent decades, cardiovascular disease remains the leading cause of mortality worldwide. Current treatments generally target risk factors individually, rather than providing a comprehensive management approach to such cardiovascular risks as dyslipidemia, abdominal obesity and insulin resistance, which comprise the metabolic syndrome.

As the first selective CB1 blocker, the effects of rimonabant on lipid and glucose metabolism, insulin resistance and reduced intra-abdominal adiposity, evidenced by a reduction in waist circumference, have been studied. Abdominal obesity is recognized as a significant risk factor in the development of cardiovascular disease.

Rimonabant also has been studied by sanofi-aventis as an aid to smoking cessation based on studies for up to one year in over 6,500 smokers motivated to quit smoking.

A Marketing Authorization Application to the European Medicines Agency (EMA) for rimonabant has also been submitted.

About sanofi-aventis

Sanofi-aventis is the world's third-largest pharmaceutical company, ranking number one in Europe. Backed by a world-class R&D organization, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine, and vaccines. The sanofi-aventis Group is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by

ress release



sanofi aventis

Because health matters

the words "expect," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2004. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

The sanofi-aventis Group conducts business in the U.S. through its affiliates Sanofi-Synthelabo Inc. and Aventis Pharmaceuticals Inc.

Press Contact :

Jean-Marc Podvin
+33 (0)1 53 77 42 23

Marion Menut :
+33 (0)1 53 77 40 76

press release



Exhibit J

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

Event Date/Time: Aug. 31. 2005 / 9:00AM ET

THOMSON
★

streetevents@thomson.com

617.603.7900

www.streetevents.com

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

CORPORATE PARTICIPANTS

Jean-Claude Leroy

Sanofi Aventis - SVP & CFO

Jean-Francois Dehecq

Sanofi Aventis - Chairman & CEO

Hanspeter Spek

Sanofi Aventis - EVP Pharmaceutical Operations

Gerard Le Fur

Sanofi Aventis - SEVP, Science & Medical Affairs

CONFERENCE CALL PARTICIPANTS

Tim Anderson

Prudential Securities - Analyst

Michael Leacock

Nomura - Analyst

Jo Walton

Lehman Brothers - Analyst

Kurt Schagenbert

River Edge Capital - Analyst

Sachin Jain

Merrill Lynch - Analyst

Edmund Kim

JP Morgan - Analyst

Elizabeth Mitchell

MainFirst - Analyst

PRESENTATION

Jean-Claude Leroy - *Sanofi Aventis - SVP & CFO*

Good afternoon and good morning, ladies and gentlemen, to our colleagues in the U.K. and in the United States. And we are pleased to report on this August 31, on the first half and second quarter and first half result, and also to have a status report on our R&D portfolio.

I will begin directly by the financials, and let's go directly to the slide. I will -- okay. I will obviously begin by the P&L, and give you a few highlights on the performance of the Group during both second quarter and first half. To begin with, at the sales level, you know very well -- no, something is going wrong. Okay. Thank you. You know very well the performance which has been made on a comparable basis, which is 10.1% on Q2 and 11% on H1.

Now on the P&L we are starting from another figure, taking into account the impact of exchange rate, obviously, and also of the changes in Group structure. So that we are showing 6.5% on Q2 and 7.4% growth in H1. So starting from that, we'll go down to the line and beginning, obviously, by the gross margin, which is an important factor in the performance of the Group.

As you can see, I'm sure you've seen in the P&L we are in a situation where we've seen in the Q2 an important improvement of the gross margin rate. And when we take that gross margin rate, as compared to the sales, we've seen an improvement by 2.2 percentage points, which is quite impressive and which translates also in 1.6 at the end of the first half.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

Now what are we talking about? We are talking about, I would say, two factors, which are behind and above the product mix, which is the volume, the activity of the Group, and that good level of activity. And when I'm saying that, I'm comparing with the market, is the most important reason of that improvement.

In addition to that, we've made -- we've decided and we've put in place rationalization of purchasing policy since the end of 2004. This is paying back. It has been paying back to begin with in Q1, a little more in Q2. I'll be back a little bit later on the synergy subject but be sure that already, in that gross margin rate, there is the result of a lot of synergies.

Now, that being said, let's go to the various expenses and namely R&D and general and selling expenses. To begin with, R&D. It might be a little bit strange to see -1% in Q2, -0.4% in full half. It's a little bit -- it might be a little bit down but, as compared to what we've said all year, we said that R&D would be increasing. Now we say also that the increase in the financing of the programs, of the clinical trials, would be more visible in the second half of the year.

In addition to that, the rationalization in the portfolio and stopping a lot of external collaboration was done by Gerard Le Fur and his team at the end of 2004. So we have all the benefit of that. In addition to that, to finish with, there were also this restructuring, which were decided before the operation, and this has an impact in R&D. So we have the, I'd say the downside of it for the time being.

And we finish up at the first half with a rate which is 14.5% in R&D, as compared to the sales. Might be low; I'm not sure that this is proper to say that it's lower nowadays. Is it better to be between the -- in the 15s or the in the 16s? I'm not so sure that the 16s is the proper answer.

Let's move now to the next important component of the P&L, which is the selling and general expenses. Again, something which is rather flat, both in Q2 and in H1. An important comment is to be made in that area. We have to split between the selling, the promotion behind the products, and the general expenses. When it comes to the sellings, the thing that we can say is that during Q2 the increase in these expenses was faster, greater than the one of the sales.

I'm just saying that it was more than 6.5% in Q2, which wasn't the case during Q1. And in turn it means that, at the end of the first half, the pace of these expenses behind the product are exactly the same as the volume of the sales. So we are saying here that we are putting as many efforts as necessary behind the products, to the contrary.

When it comes to general expenses, we see the result of rationalization, of closing down 70 headquarters around the world, and taking care of expenses, general expenses all around the world. There were -- there was a decrease in Q1. There is an even greater decrease in Q2 in these expenses, and that's only by adding up these two different items that we show something which is rather flat.

So that, when it comes to the level of the operating income current, we are talking of something which is rather impressive. I mean 24.4% increase in Q2 and a 26.1% increase at the end of the first half. It's 5 percentage points increase on sales as compared to last year, and I was saying 1.6 as far as the gross margin concerns. So you see the difference of the impact of the various expenses which are in between.

I guess that here we are showing the -- in a way, the level of the synergies which have been put in place during that first half. You've maybe noticed that we've given some indication about the level of synergies. Obviously not reporting with figures on the first half but maybe globalizing our -- the merger is going on, on a synergy-wise.

What we can say today is that when we announced the operation, we said that by the end of 2005, on a cumulative basis, we were ready to reach 60% of 1.6b. Here I accumulate the positive and the cost cutting synergies. Today we can say that at the end of 2005 we are going to be able to make at least 75% of the same amount. So we are no more talking, again, on a cumulative basis of 960m before tax. We're talking of above 1.2b.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

There is a direct relationship between the improvement in the operating income current and the achievement, as far as the synergies are concerned. I have to add up to information that we are not revising the level of the global synergies to be reached by the end of the program. We said 1.6b. We don't change that just because our Group is moving, is growing. And so we need the people behind the product. We need the people in the plants to have the Company moving faster, and to globally in R&D, obviously, to develop the Company.

So we are not changing the target. We're just saying that we are moving quicker than we thought we would be moving. In addition to that, and there is a direct relationship in what I'm going to say, just on the restructuring cost, we've accumulated the 611m during the first half.

I remind you that we were at 557m by the end of 2004. So I can say today that, on a cumulative basis, the restructuring costs are around 1.2b before tax, obviously. And when I remember that we said that we would be encountering around 2b of restructuring cost, I can say today that we will have -- we will be able to achieve our program with a lower amount. Probably more in the range of 1.5b, 1.6b of restructuring costs.

Let's move now to the rest of the P&L. There are a certain number of particular specific items I will be back on, such as the restructuring costs, which are Aventis pre-acquisition program and so on. So I won't spend too much time at this level, and be back on the particular slide to show you the impact of these items.

Let's just say that -- sorry, as you can see here, that there is obviously a big difference in the gains on disposals when you compare 2004 and 2005, just because of the fact that applying the policy that we defined when we launched the operation, we are not selling products anymore. We are just promoting products. Again, I'll be back on these specific items. So again, on the operating income level, a good increase both on the second quarter and on the first half. That's the same on the second half -- on the first half.

So let's go down to net financial expense. Again, I will leave the so-called exceptional items. I'm talking of the effect on provisions from listed securities and financial instruments for a little bit further in the presentation. And let me say that, as for us, the financial costs are a concern.

I can tell you, and it won't be a surprise to you, that because of the generation of cash flow, because of the renegotiation of the acquisition, that better conditions, obviously we do have lower interest rates and lower interest costs in the P&L in 2005 than we had in 2004. And this is true both in the second quarter and on the entire semester.

As far as the tax rate is concerned, as you see on this slide, we are above last year - 30.6% in Q2 versus 28.9% last year, 31.2% in H1 -- in the first half as compared a little bit lower, less than 30% in the first half. I just have to remind you that on the entire full year 2004, the rate was 30.8%. So you see that the tax rate of the second quarter and first half of 2004 were maybe not totally representative of what was going on in 2004.

And just to say that in 2005 we should be closer to that 30.8% for the year. So I don't see much difference in that level -- in that effective tax rate during -- as compared to 2004.

Not many comments on the share of profit/loss of associated minority interests. I just have to -- probably to remember that because of IFRS we changed our way of accounting, as far as the BMS share of profit are concerned. Now, and this is true, obviously, in the comparison with 2004, we have the BMS or I should say the [out] share of the profit generated on the alliance. Mainly in the United States, which is managed by BMS in the share of profit of associates. Our share is that -- is there.

I will go directly to the minority interests because there is the same kind of explanation. Here is also the share of the profit, which is derived from the management of the alliance with BMS, which is managed by Sanofi Aventis, so that a part of the profit is rendered to BMS.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

What is interesting, when you see the evolution between 2004 and 2005, is that it's -- as said, the evolution is mainly derived from what is happening within our alliance with BMS. This is shown directly on the slide. I won't talk too much about the other share of profit in associates, like Meriel and so on, which are doing well. But I wanted to mention that the majority of it is derived from what's going on and what is going well on the Plavix and Aprovel alliance with BMS.

Therefore we can go directly to the -- to adjusted net income and adjusted EPS. And I guess you can consider that it is rather impressive to be able to show up to close to 25% in the second quarter on an EPS basis, as compared to last year. Which translates in 26.1%, at 2.22 on the first half. And more importantly, to remind you that this is an increase by 3.4 percentage points, when compared to the sales. So we are reaching now 22.6%, which is -- which can be compared to the competition.

Let's move quickly now to what I mentioned, the trends in selected components of adjusted net income, like we presented on March 1, to [indiscernible] in the P&L of last year or this year something which doesn't translate very clearly in the lecture of the P&L. We have gathered there restructuring costs, which are Aventis pre-acquisition programs, the gain and loss, as I mentioned earlier, on disposal of assets and defense costs encountered by Aventis last year, as well as the provision for listed securities and financial instruments.

As you can see directly, when you compare second quarter you see a difference between - 38m and - 24m, and we have been before tax of 14m.

Now what has -- we have to compare that with the result before tax of the full Group on the second quarter. We're talking of 2.1b. So 14m we can say is negligible. On the first half, we're talking of 20m as compared to 4.2m. So we can say today that the comparison between 2004 and 2005 is very clear, and in addition to that, 2005 is not burdened or doesn't benefit from any so-called exceptional items. So the lecture of the EPS performance is rather clear. It reflects the economic performance of the Group.

Let's move now to the simplified statement of cash flow. The end of the day -- at the end of the day we're showing an improvement by 1.4b in the free cash flow, which in turn translates by a reduction of the net debt of 1.4m, going from 14.2m to 12.8m.

More interestingly, I should mention, if you see the detail, that when you want to make what I would call a good comparison, I mean by that excluding dividend, just because of the fact that I'm comparing six months to one full year and the dividend burdened the first half of 2005. When I exclude also, on this side, the asset disposals, which were exceptional last year, we already explained the components of them, we can see that on a full year last year, we generated + 4.1b. But on the first half we generated 2.9b.

I guess that, again, it does show everybody that cash generation in 2005, at least in the first half, is a lot weaker than in 2004. So we are comfortable to say that what -- our intention to reimburse the acquisition debt within five years, we are quite on track on this one.

To finish up on this one, the gearing ratio is better. It's also partly due to the conversion rate of euro versus dollar. So it's the first comment and probably one of the -- the only comment I will make on the next one, which is the balance sheet, to finish on the financials. There seems to be a lot of changes between figures, between the end of the -- of last year and this year.

Let's just -- let me remind you that the exchange rate of the euro versus dollar was 1.36 on December 31, 2004. It's 1.21 on the first -- on June 30. We're talking of 11.5% different, and this is the main component of the evolution of the various components of the balance sheet. Shareholders' equity, for example, there is a positive impact of currency, + 3.6b.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

If I go on the main part of the assets, intangibles including goodwill, there is a + 3.5b improvement balanced by 2b of amortization. But this is the main source in, I'd say, almost each of the components of the balance sheet. It's more that currency than anything else, which explains the movements between the two periods.

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

Thanks Jean-Claude. I think that Hanspeter now on the operations.

Hanspeter Spek - *Sanofi Aventis - EVP Pharmaceutical Operations*

Yes, thank you. Hello, all of you out there. I have given, I think, a lot of information on the performance of our products, at the opportunity when we presented our sales results before the holiday season. So what I will try to do today is to comment more on the market performance, and in front of this market performance, of our own performance, to give you some insight.

So let me start with the major trends in the markets. The chart may be a little bit confusing on first glance, so it takes a time to look to it. So what you see, of course, common knowledge, the growth of the world market is slowing down. Why is it slowing down? In very simple terms, because the very, very strong slowdown of the U.S. market cannot be totally compensated by a Europe which behaves relatively well.

When we went into CCL we had a lot of negative connotations on the future development of the European market. We have to say today that they did not entirely come true, so far at least. And then we see the two other trends, very important.

A very, very strong trend in Japan, very positive. Unfortunately this will not be entirely repeated. You know that there is a two-year term when Japanese prices are being revised. On top there has been a very good season for antibiotics and also antihistamines this year in Japan, which pushed the development. Nevertheless it is good.

Even better, the performance of the so-called rest of the world market, or in more modern terms the BRICs - Brazil, Russia, India, China. Also the developing markets contribute very strongly to the upswing you see in the market growth of rest of the world, which is then the light green column.

So overall, yes, we have a difficult environment, which is much more difficult than, let's say, one year ago. But nevertheless, has remained reasonable. Also today this is a market which is growing by more than 6% on a worldwide basis and, yes, those are the realities. But to say, of course, many other markets which show much, much less growth than the pharmaceutical one, and why? For the reasons outlined in the chart. You know them at least as well as I do.

How did we behave in front of this market? Yes, allow me to say I think well, even pretty well. We repeated once again, also during the second trimester, very, very solid two-digit growth rate. You see from the charts this is very homogenous. Between the two parameters we measure our sales performance. One is consolidated, the other one is developed, essentially the sales through BMS. So you see that both growth rates are between 11 and 12%. So, yes, we are doing fine.

First look to the portfolio. Also portfolio you see a very good trend towards the star products, the key products, the leading 15, which increased their share from 59% in the total portfolio to 63%.

As an angle to our performance, of course, the geographical one. How do we perform against this market on a geographical basis?

You'll see on the slide that we do overall worldwide, very simple, because we do everywhere better than the market. And consequently, yes, we have been in the first half of 2005, see a most important contributor to worldwide growth of pharmaceutical

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

market. Again, in very simple terms, about 10% of our new sales of the pharmaceutical market came from this brand new Group, Sanofi Aventis, during those first six months. Consequently, of course, we have gained market share, which is rather obvious.

The growth is driven, as said before, by the key products. They are growing by 17%. But it's also driven or secured, perhaps better said, by all the other products, which are growing by 2%. And I will get back to this when analyzing the portfolio performance more in detail.

In the markets you have seen before, everywhere we are doing fine. More then in detail. The U.S., where we turned meanwhile to be the number four of the leading companies. So we also are important in terms of size meanwhile in the U.S., and we have a growth rate which is twice the growth rate of the market. You'll see once again we behaved very well also in Europe, where we are specifically proud because we have a very, very large market share in Europe of nearly 10%, as you know.

And then once again, in intercontinental, in rest of the world, where we had a little bit of a bouncy start at the beginning of this year. But meanwhile we do more and more well.

What are the perspectives of the U.S. market? Frankly, I don't believe that we will see much change before the end of the year, and then you need a crystal ball to know how 2006 will work out in terms of the extension of the Medicare plans. But so far what we see is we do good against the market, and we even increased in the recent months the gap to the market. So already from this, I think we have all reason to be confident.

Perhaps even a little bit more important, we have products to launch in the U.S. The launch of Ambien CR is very, very imminent. I would like to give you more information on that, but we are a little bit still bound to our contacts with the FDA. But believe me, we are very, very optimistic that this launch is very, very imminent. So perhaps during the question and answer session, we may discuss again a little bit further.

Second important element, this market undergoes restructurization. As you know, there is a reorganization of the relationships between the wholesalers and the industry. We are very well advanced in this. I am confident that we will sign those agreements, which are based on services and no more on overall margins, during the ongoing semester. And this is, of course, an important step in order to have a solid basis for the upcoming changes on the managed care front.

And there, if you look to the lower right part of the chart, you'll see that we have once again in the last six months significantly even increased our segment Tier parts for all of the major products. And this from very, very high levels, which range then between 36 or 38%, up to 83%, and now they go even up to 85%. So we take this as a very, very positive basis for the upcoming negotiations with the healthcare providers, in the light of the new changes as from 2006.

Last but not least, from a geographical standpoint, if you look for a weak point inside Sanofi-Aventis it has been and still may be a little bit Japan, but also there is very good news. As you see from the chart already, we have a very strong acceleration of our growth in the Japanese market. Consequently we have been the strongest growth company in the first six months in 2005, amongst the leading 20. So we are reasonably proud for this.

We are also confident because there is more good news ahead, as you have realized, during the second quarter. We have renegotiated all of our agreements with Daichi, which are very favorable for us now because, consequently, we have ensured that all – 100% of the commercial rights of Plavix have been transferred to Sanofi-Aventis. And consequently, we are in the final stages to prepare the launch of this very, very important product for our future, not only in Japan, during the rest of the year, to be ready to launch during the first quarter 2006.

So far, on the portfolio I make a little reminiscence of what has been said much, much earlier. No small products and no small countries. So I made my comments on the countries, now on the small products, the so-called base business.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

As you may see from the chart, this base business overall is very important for us as a Company. It represents nearly 40% -- still nearly 40% of the business, but the importance very strongly, let's say, between the U.S. where it represents only 13%, up to 59% in France and, let's say, in Africa and Middle East. So we have to have an original approach to this, which is exactly what we do.

We have given very clear targets, very clear methodology. It's hard to assess the potential of those products. And what we see is, yes, we start to harvest the fruits of this development of this part of our overall strategy, the portfolio which had been strongly negative in the legacy Aventis turned to be stable already in the -- at the end of 2004. And now for the first half of this year we can report a growth of nearly 2%.

And it is exactly this which builds now the real focus for our overall growth, which of course has to come from the key products, from the leading 15. And you have in a very short summary the performance of those products here. You see this Company today has seven own blockbusters to show. All of those products, with the exception of Ambien, have a two digit, even a very high two-digit growth during the first year of -- during the first half of 2005.

And you'll see that those products play the leading, or at least one of the leading roles in the case of Taxotere, within their therapeutic field. And also therapeutic fields account to the most important and also to the most dramatic in pharmaceutical industry and medical science.

Now we have everything in place to enlarge this list, through Rimonabant, Acomplia. We have once again delivered what we promised. Gerard has deposited with his people the files with EMEA and FDA exactly on time. We know that the products have been received, that they are of course fileable. And we are now starting to prepare the market and, in parallel, our contacts with the FDA and with the EMEA continue, and we are on a very good trend.

Why? Again, nothing really new but there is a big interest for this product coming from the overall situation. Obesity, it's a more and more growing understanding that obesity is a predecessor and an early indicator for following cardiovascular diseases, and it's in this slide that we follow the actual debate on an academic level. If the metabolic syndrome exists or not, there's a lot of interest but without any excitement because this is not really the core of our interest and the core of our positioning.

The core of our positioning is the cardio metabolic aspects, and the consequences on the cardiovascular field. So, yes, we follow this debate but as I said, without any excitement.

With a lot of excitement we have initiated the Phase III program, totally in line with this positioning; you see it on the chart. We go in again once in those subsegments like diabetes, like dyslipidemia, like cardiovascular. And you see that overall there have been five large trials stratified this year.

So it is -- and meanwhile also initiated. And, of course, there is included also a large trial on morbimortality in the cardiovascular field, which of course is very important for the future for the segment or first step development of this product. So with Acomplia, Rimonabant is -- everything is doing well, and we advance well also with our first contacts with the future players, especially in the U.S. And once again, we are very much supported by our strong positions we hold today with the managed care providers.

An important word now on our vaccine division. The vaccines unfortunately have been in the past a little bit out of the limelight. You'll see that the vaccines have an excellent performance in the first half of 2005. They have fully contributed to the overall development in the Group, showing once again a two-digit growth, as the pharmaceutical operations.

You see, if you look into the two columns, that this is a development which is not at all only due to the success we have with the [anti-trip] products -- anti-flu products, excuse me, but also with meningitis and with the boosting of vaccines for adult people. So it is a growth which is very solid, and driven by three of the major activities of our today's vaccine business.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

Within, Menactra plays a very, very important role. This is the most recent launch in the field. It is a revolutionary product and the results are, I believe, spectacular. As you see from the chart, sales have more than doubled in the first half and reached nearly 100m. So, yes, Menactra already today is one of the most important vaccine products at all. And everything is in place, and we will do everything to leverage the potential of this very, very important product, also in the future.

This is overall true for our position in vaccines. You are -- you know, of course, we are leader. Our President has stressed from the very beginning that he feels that the vaccines in the past have been insufficiently supported. So we do everything there to accelerate, which means in first line, of course, investment but there is also a lot of opportunity. And I'm sure that you'll get back to this during the question and answer session; it definitely merits.

So I think, at this point of time, I'm now ready to summarize. Once again, it is short and it is totally in line with what we -- what I have said before. The priorities for the rest of the year remain exactly the same. We will continue to outperform the pharmaceutical market, as we have done so far.

We will do so by leveraging the three major parts of our portfolio - vaccines, base business and blockbusters. And this is really a unique and beautiful combination, and an opportunity. And so consequently, we will continue to exercise our leadership in all key geographic areas where we are present. And, yes, in parallel and very importantly we will prepare our future by launching the new products, and we have rich opportunity in front of us.

Ambien CR ready for launch tomorrow. Plavix in Japan. And, of course then, overall in the world, Acomplia during the next 12 months.

So thank you so much for your continued interest.

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

Thanks Hanspeter. Now Gerard on the new -- the news and the new news in R&D.

Gerard Le Fur - *Sanofi Aventis - SEVP, Science & Medical Affairs*

Thank you. Hello everybody. So since I have quite a few slides, I will start right away, if you agree, with the first one. We have eight products entering the R&D portfolio since last March, last meeting. In fact, three of them are in the oncology area, two in the CNS area, one in malaria, one in COPD, and one in diabetes. The atypical compound is only Alvocidib, which was in the past Flavopirodol. And I will explain to you why, in fact, we start next year directly in Phase III in CLL, and I will explain that later on.

So, we stopped the development of eight compounds during the same period - two in Phase IIb, three in Phase I, and three at the pre-clinical level. However, concerning the so-called two compounds in Phase IIb, Pranalcasan in fact was already annulled by Aventis, and we only decided not to start again the development of this compound.

In fact, among the seven compounds which are right now in Phase IIb and III, and that we present the results, the only negative results we got was with Osanetant in schizophrenia. And we were unable to reproduce what we got in Phase IIa in this Phase IIb study, which was validated by a reference compound. And for that reason, we decided to stop the development of this compound. Most of the time we stop compounds in Phase I, mainly because of a not good enough safety ratio. And most of the time we stop compounds in the pre-clinical development because of toxicological problems.

Concerning the vaccines, 2005 was really a very good year, so following Menactra, that Hanspeter already talked about. As you saw, we've got the approval with Adacel last June, and we already filed Pentacel very recently in the U.S.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

And several other vaccines move on but maybe the most important results we got was obtained on the prototype vaccine on avian flu, the H1 -- the H5N1 strain. And that we got preliminary good results with this compound, meaning that be sure that we'll do everything we can do, if some day - and we'd hope it will not be the case - there will be a pandemic of flu, pandemic of flu avian pandemic.

We stop eight compounds, we enter eight compounds. That is to say that we still have 128 compounds in -- under development. More than 50 of them are in Phase II and III. And even more important, we have finally 35 compounds in late stage. That is to say, in Phase IIb and Phase III.

A few words about cardiovascular, as we mentioned cardiovascular earlier. As we mentioned previously, we filed in June dronedarone, both in Europe and United States. And I can tell you that dronedarone is fileable; in other words, we received a letter coming from the FDA, meaning that they accepted the dossier. So in other words, we are ready to start to answer the questions to the FDA with dronedarone.

So, concerning thrombosis, we have two compounds that we are testing in the prevention of venous thromboembolism in patients with atrial fibrillation. These compounds are Plavix, with the active program, and idraparinux with the Amadeus program. The steering committees of both trials have observed substantial lower incidents of events than initially planned in this study. So we were told to increase the sample size of both trials.

However, we decided in agreement with the steering committee and the DSMB of the Amadeus program not to go on, not to increase the sample size, for we were told to more than double the number of patients. Therefore, we decided to stop the recruitment of this clinical trial and we'll have the results of the Amadeus program in 2006.

I can tell you that the Amadeus program is only one of the four studies that we have currently in -- of the four Phase III studies that we have currently with either idraparinux. The so-called Van Gogh program, which is the treatment of VTE, the treatment of PE and the long-term extension is doing very well. That apparently with enough events and that all the patients are recruited, and one more time, we do hope to have the results of these three programs in 2006.

On the opposite, the steering committee proposed to ask to increase the number of patients in the active trial, in the clopidogrel trial, by 1,000 and 500. So we agreed and we'll do it. So, in other words, we still do hope to have the results of such a compound in 2007.

Concerning CNS, as Hanspeter already mentioned to you, I can reconfirm what we said last July. In other words, we still believe to get the NDA of Ambien CR before the end of summer. Secondly, concerning xaliproden in Alzheimer diseases, we recruited all the patients of the two Phase III studies that we have with this compound. The follow up of this -- of both studies are 18 months. That is to say that we'll have the results of these two Phase III studies in 2007.

And I will present to you results of three compounds - VSR 58611 in depression, which is currently in Phase III in depression; the partial nicotinic agonist, which is currently in Phase IIb for smoking cessation; and eplivanserin, which is also in Phase IIb in the maintenance of insomnia. Maybe there's no need for me to comment that, except that you know that we have quite a lot of compounds even in Phase I and the pre-clinical level in the CNS area, quite of them being first in class.

Concerning oncology, I will present to you two results, the first on the ex-flavopirodol, alvocidib, and I will present very new results with a new regiment in CLL. And a very interesting result with xaliproden in general therapy in use, neuropathy, which is quite important for sure for oncology, but also as a proof of concept study for the neuroprotective activity of this compound.

Concerning metabolic disorders, I'll just remind you one more time that Acomplia is fileable and we are starting to discuss with the authority concerning the dossier of this compound. And then for Exubera, the compound that we share with Pfizer, the inhaled human insulin that we share with Pfizer, that there will be an advisory board on this compound, September 8. So in other words, we have quite quickly new news coming for this compound.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

So concerning internal medicine, I will present to you two Phase IIb studies in the cirrhotic ascites patients with the V2 receptor antagonist, the aquaretic agent that is currently both in Phase IIb for ascetic -- for cirrhotic ascites, and in Phase III for SIADH.

We already mentioned to you that, concerning vaccines, Menactra is really a blockbuster. And I'll just remind you that we file for this vaccine for young people, for two to ten years, and that we are currently in Phase IIb study with Menactra in total. And again, one more time, that we do everything we can concerning the possible flu pandemic with the -- a prototype vaccine we have on H1 -- H5 and 1.

So right now I will present to you the positive results that we got with six products which are in Phase IIb and III, and the first one here, the beta-3 agonist in depression. Here you have the protocol of the European study but, in fact, we got exactly -- we have exactly the same protocol in the United States. That is to say, a comparison of the SR compound versus Paroxetine, which is an SSRI, as you know, and versus placebo in recurrent major depressive patients.

So, as you can see here, the primary endpoint is significantly different from placebo, and the SR compound is at least as active as paroxetine on this endpoint. Moreover, when you consider the percent of patients with Hamilton Depression Score of less than eight, that is to say with patients with normal depression, we have roughly close to 27% of the patients which are under eight in the SR group, compared to 20.6% with paroxetine. This is a trend in favor; also, it is not significant.

Moreover, I can add that in more serious patient, that is to say in patients with baseline Hamilton Depression Scale above 25, apparently SR was even more potent versus placebo than it was in older patients. And it fits to what we got in Phase IIa. I reminded you that in melancholia, in Phase IIa, in proof of concept study, the SR compound, we have shown that this compound was more efficient, significantly more efficient than paroxetine in this compound.

However, in the American study, their study was inconclusive. That is to say, that in fact paroxetine itself was not significantly different from placebo, and this was also true for the SR compound. So in other words, we got - as it is very often the case - a very high success rate response with placebo in this study. And it is well known that roughly half of the Phase III studies with the antidepressant agents are quite often non-conclusive.

However, if we can say anything about potential activity in the American study, we decided to merge both studies for the safety. And as you can see here, and it was already the case in Phase IIb and in Phase IIa, the SR compound is very, very well tolerated. The only side effects reported are some GI disorders, which are mild and transient, and possibly this compound, opposite to SSRI, has no effect on the decrease in libido. It does not decrease libido.

So in other words, very good results in Europe with a very nice safety profile with this compound. Also we got a non-conclusive study in the States, and that this compound is very, very well tolerated. So we are quite happy to have for the third time a positive result with this compound.

A few words about Eplivanserin in sleep maintenance insomnia. As you know, the compound is -- it's a new concept for insomnia. We demonstrated by polysomnographic studies that this compound increases the slow wave sleep. That is to say that it is the good sleep, and we were able to demonstrate that by very objective parameters. But maybe, even if it is a little bit more complicated, we just wanted to have the feeling of the patient.

So we performed a Phase IIb study, where it was a comparison of two doses of Eplivanserin versus placebo. And we measured the effect, the feeling of the patient, by a visual analogic scale, in order to see whether, with this objective activity on slow wave sleep, we are able to get a positive result when we ask to the patient. And that's exactly what we got.

The primary endpoint was the WASO, and as you can see here, there was a very significant increase -- decrease in WASO versus placebo, 5 milligram Eplivanserin, and a trend to increase even the TST with this compound. Moreover, the number of awakenings are even more decreased under 5 milligrams of Eplivanserin than under placebo.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

However, as expected, this compound is not a sleep inducer, like Ambien, and it has no effect on the question, how long after going to bed did you fall asleep? No difference versus placebo. It is not at all a sleep inducer.

Thirdly, this compound concerning the sleep quality has a significant effect on the so-called refreshing quality of the sleep. And the trend versus -- the question, how would you describe your sleep last night?

What about the next day residual effect? We got no next day residual effect, by the two questions we have here - do you feel sleepy this morning or how would you describe your ability to concentrate this morning. And even the trend, even if it is not significant, is in favor of the compound versus placebo.

So you can see moreover that the compound is very, very well tolerated, roughly no difference versus placebo and roughly no side effects at all. So in conclusion, it's really a new concept in insomnia, and you know that we are leader in this area. Compared to placebo, this compound reduced WASO and the number of awakenings. There's a trend in the increase in TST and improved the refreshing quality of sleep. Moreover, the next day we got no residual effect and no rebound. So for all these reasons, for sure we'll start Phase III study with this compound in 2006.

To us right now, for a compound which is -- which was in Phase IIb in smoking cessation. This compound is a partial agonist of a nicotinic receptor, the alpha-4 beta-2 [indiscernible]. And we compared this compound -- compared three dose of this compound versus placebo, and the main -- the primary endpoint was prolonged abstinence during the last four-week treatment, which is the primary endpoint accepted by the FDA.

Moreover, this abstinence was documented by biological parameters, that is exhaled CO measurement and the plasma cotinine level, which is the metabolite of nicotine. You have here the protocol of this Phase IIb study, which is, I would say, quite classical right now. And you have the results on the primary endpoint, both ITT population and for the completers. And we roughly, for the higher dose, we got a very nice dose response curve, and we roughly tripled the response rate versus placebo with the higher dose.

So concerning the side effects, these side effects are, let's say, manageable and correspond to what we expected, which was already the case with nicotine patch. That is to say, GI disorders and for again that reason, we start Phase III study with this compound in smoking cessation next year.

As we mentioned to you, we got a very significant effect on the primary endpoint, which is the abstinence rate in the last four weeks of treatment. And this was confirmed, as I mentioned to you, with biochemical parameters and with a classical and acceptable overall safety profile.

A few words about the V2 receptor antagonist, which is an antagonist of anti-diuretic hormone, a V2 receptor in the kidney. And we tested three doses of this compound versus placebo in cirrhotic ascites patients, on top of diuretic. That is to say, on patients which was -- which were, I would say, very, very ill, and the first study it was a so-called HypoCAT study. That is to say, patients with hyponatraemia.

So serum sodium was the primary endpoint, for sure, with a change in body weight. This compound, as it was already the case in Phase III, increase urinary output, increase urinary excretion and only water, since it is an aquaretic, nothing with ions. However, as expected, concerning the primary endpoint, that is the serum sodium level, we got a very significant versus placebo increase in the mean serum sodium level, starting from the lower dose of 5 milligram.

In a similar manner in the composite endpoint, which roughly corresponds to a decrease in body weight, we got a very nice response curve. Which indicates that in these patients, definitely, this V2 receptor antagonist is active. So we also tested this compound in other patients with cirrhotic ascites but which are normonatraemic. That is to say, no difference in the sodium level in the plasma. So the primary endpoint for sure can be plasma level nataraemia, but it was change in body weight.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

And one more time, since they were very ill patients, it was already untreated patients, both on spironolactone and furosemide. So one more time, in patients which are very difficult to treat. And as it was the case in the previous study, we got a very significant effect, more than 2 kilogram decrease, starting from the lower dose of 5 milligram. So the primary endpoint was reached by this compound.

And concerning the side effects, we do the study and the only significant side effect we got was, I would say, classical for this compound, which increased urinary output. It was thirst. So in other words, this compound was very safe and active in cirrhotic ascites. One more time, we start Phase III study with this compound in 2006. This compound was active both on hyponatraemic patients and on normonatraemic patients.

A few words about flavopirodol or Alvocidib in CLL. Just remind you that this compound is a very potent and selective inhibitor of some kinase, which are deeply involved in oncology. And I remind you that this compound was stopped by Aventis because, by using only infusion, as you can see here, continuous infusion, they got no response rate. And a very poor response, a very poor, partial response after one-hour bolus.

But very recently, a so-called NCI study, which corresponds to bolus plus infusion, we got a very, very nice response in CLL, and maybe what, a 43% partial response. But what is quite important, that it was in patients resistant to classical treatments, such as fludarabine. In other words, we got roughly the same response rates in fourth line with flavopirodol, and we got roughly the same result that was obtained in first line or third line with other reference compounds.

So in other words, for CLL such compounds are very, very impressive, and these very impressive compounds are associated with a very acceptable safety profile. Just to remind you that for sure it is an anti-cancer agent, and especially this compound induced a very classical Tumor Lysis Syndrome, for sure, which is a side effect but which might also be considered as a surrogate marker of biological activity.

And we talk about -- quite a lot about the so-called Tumor Lysis Syndrome, so we developed rasburicase in order to prevent such a Tumor Lysis Syndrome. So really, we are very happy to start again in Phase II, in association with NCI, with flavopirodol, because of the safety profile of the compound and because of its activity.

This compound, as I mentioned to you, roughly has the same activity in resistant patients that was obtained in first line patients with fludarabine, for instance. And this response rapid and prolonged. It was independent of so-called high-risk genetic markers, and possibly by historical comparison, the safety of this compound seems to be or possibly might be superior to reference compounds. So again, one more time, in 2006 we'll start Phase III study in CLL with this compound.

And to finish, just the last result we have, the effect of xaliproden in chemo-induced neuropathy. I mentioned to you that xaliproden is currently in Phase III as a possible disease-modifying agent in Alzheimer disease, and that we recruited all the patients this summer. And with a follow up of 18 months, we'll have the results of these two Phase III studies in 2007.

Xaliproden has neuro-protective activity and stimulates neurotrophic growth, certainly through the production of a growth factor such as NGF. And here you have a model -- a so-called model of Alzheimer disease. NGF, when it is injected in the brain, is able to counteract the effect of increase in the hippocampus. And this we got roughly similar results with xaliproden, except that xaliproden was administered by oral route once a day, in the same model.

So first slide of the hippocampus, this is the control. The second slide in the hippocampus, you have the effect of vincristine, which induces a very dramatic loss in neurons, which was third picture. Which was fully antagonized by xaliproden. And it is a model in animals for sure. It is a model of Alzheimer, since this decrease in neurons induced a decrease in memory, which was reversed by NGF injected directed in the brain, but was -- which was also reversed by xaliproden administered by oral route. And we got again, one more time, similar results with xaliproden oral route than with NGF injected intra-cerebrally.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

So it's well known that anti-cancer agents, and especially Platinum compounds, induce neuropathy, and this is the case, for instance, of oxaliplatin. So we decided to try to see whether, first of all in vitro, xaliproden is able to have neuro-protective activity versus the decrease -- the aggressiveness, let's say, of oxaliplatin versus neurons. And you have, and you see here, that in DRG explants alone, xaliproden is active per se.

However, it's even more potent when we add, let's say, glial cells. So in other words, in vitro xaliproden is able to protect neurons versus a neuropathy induced neurotoxicity, induced by oxaliplatin. So the next question is very simple, what about in vivo? And it's possible to reproduce the cold allodynia that we got in humans with oxaliplatin.

It's possible to reproduce it with animals, with rats, and as you can see here, the neurological score increased under oxaliplatin treatment versus Sham, that is versus placebo. And that this increase in neurological score, that is to say in cold allodynia, so in neuropathy, is fully reversed by a 3 milligram and 10 milligram per kilo oral route with xaliproden. So that compound is active in vitro and in vivo in animals.

The next question is, the decrease in side effects in vitro and in vivo induced by xaliproden, does it correspond to a decrease -- in an overall decrease in activity in oxaliplatin. So in other words, does xaliproden change the anti-cancer activity of oxaliplatin in animals? And the answer is no, and we performed the following experiment.

We injected colon adenocarcinoma to mouse, and after a few days there was, this corresponds to the control, let's say, the dark line. There's an increase as a function of time in control animals of the size of the tumor. Xaliproden itself, it corresponds to the blue circle. Xaliproden has for sure no effect on this increase in tumor size. Oxaliplatin alone, which corresponds to the red circle, has a dramatic decrease in the tumor weight after two injections of oxaliplatin.

If you add xaliproden to oxaliplatin, it corresponds to the green circle, no difference versus oxaliplatin itself. So in other words, xaliproden has no effect on the anti-cancer activity of oxaliplatin. After a few days since we stopped the administration of oxaliplatin, and this corresponds to the, one more time, to the red circle, there was, one more time, an increase in the tumor weight in the animal. But again, when we add xaliproden, no change versus oxaliplatin.

So, in animals we demonstrate -- we demonstrated definitely that xaliproden has no impact on the anti-tumor activity of oxaliplatin. So it's really a neuro-protective activity and not a decrease in the activity of the cancer -- anti-cancer activity of oxaliplatin.

So knowing that, we decided to build up the Phase III study, a study versus placebo, so all the patients received the FOLFOX4 regimen of oxaliplatin, and they received either placebo or xaliproden. And you can see here the results of the probability of a first onset of grade 3 peripheral neuropathy. Grade 3 are really the very important neuropathy which are in use by oxaliplatin.

As you can see here, the green, which corresponds to xaliproden treatment versus the blue, which is the placebo, there was a very significant decrease in the probability of first onset of grade 3 study, with the hazard ratio of 0.61. That is to say that there's a relative risk reduction of 39%, a significant 39% in grade 3 PSN, peripheral neuropathy. And this effect for sure is very, very significant.

So what about the anti-cancer activity of oxaliplatin? And as you can see here by the effect on response rate, progressive disease, and so on, we got no difference versus placebo. So, in other words, even in humans for sure and fortunately, xaliproden has no effect on the anti-cancer activity of oxaliplatin, although it decreased the side effects, the neuropathy induced by these compounds. And, as you can see here, concerning the side effects, we got roughly the same profile versus placebo of xaliproden here.

So in other words, both in vitro and in vivo, xaliproden in animals was able to significantly prevent the peripheral neuropathy induced by cumulative dose of oxaliplatin. We were able to reproduce this effect in humans and this corresponds to a neuro-protective activity, that for sure will be very interesting for patients which are treated with oxaliplatin.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

But it's also a proof of concept study, showing that in humans xaliproden has neuro-protective potential whatever the activity of this compound, in both oncology patients and in possibly patients in neuro-degenerative diseases.

So in order to conclude, I just would like to say that last February we mentioned to you that we'll have more than ten results on compounds which are currently in Phase IIb and III. But right now we release seven results and only one was negative in Phase IIb. The others, six others, are positive and especially four are compounds which were initially -- which were in Phase IIb, which are positive, will be in Phase III in 2006.

So in other words, the success rate that we got was much higher than we thought, and that's why we are very, very confident in the future, one more time, of our portfolio. Thank you.

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

Thank you Gerard. Just perhaps to finish quickly, a short -- some words on where we are after one year.

I think that you'll remember that we have a very clear and simple objective. This objective is to have a strong, sustainable, and profitable growth. That is important because it's easy to have a profitable growth by cutting the costs and having nothing in terms of sustainable. And if you cut the costs and if you have just a very small growth, I think that the future is not very clear. So we continue to fight for strong, sustainable and profitable growth.

What we can say? We can say that, yes, perhaps it's not to us to say that, but I think that clearly that the integration of Sanofi-Aventis is something which is a success now and it's key for our results. Why this merger, this acquisition is a success? I think that the clear strategy is something very important. As soon as you have a clear strategy, which is exactly what we said in January '04.

We asked to the management team to be totally united behind the project, and that's something which is very important. And we have a team, a management team totally, as I said, behind the project.

Further the way to make a very speedy and -- very speedy decision and implementation, and what could be said is yes. We made a very speedy decision and the implementation of our decision, and especially during this first part of the year, was very, very quick.

At the same moment, respecting employees and improving motivation. I think that if we succeed in these results, it's only because the management is totally devoted to the project. But also because the majority, the large majority, of our employees are totally motivated behind this project. Because they know very well that if we succeed in such a project, with a strong growth and defending the future, it is their future which is in front of them. So we have to thank certainly the people. All the employees are running behind the project.

Something which is very important. You'll remember that one year ago, when we starting -- when we started to speak around synergies, it was not so clear or believable for many people that it could be possible to make these synergies. And many will say that yes, but it will be so difficult in France and Germany and so and so.

What is clear now is that synergies are on target even in France, even in Germany, and that's something which is important. As said before, Jean-Claude Leroy, all the synergies will be finished at the middle of '06 and we are really faster than expected.

Strong growth. Hanspeter told you of the figures. 11% is not something which is current in this industry today, and you know very well the figures of our competitors. I think that the market is more and more difficult, and especially in the States. And to succeed by double-digit growth is not something which is very impressive, it's even for me impressive.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

I think that looking at the 15 top drugs because, okay, you can say that Plavix is a problem because nobody knows what could happen in the trial. Yes, but we have 15 products and a lot of them are running very well, and it's not -- this Company is not a one-product company. It's a company with between eight and ten blockbusters, if we are looking not only at the pharma products but also vaccines.

What is also very important is the fact that this famous base business, which is in many, many companies decreasing, you know that in our objective we say that there is no small product, no small country, and we are fighting on all the products in all the countries. And the stabilization in '04 was something but, if you look at the beginning of this year, we have a growth in '05. And as Hanspeter gave the figures, I think that it's very important if you look at how -- what is the weight of this famous base business in some areas around the world.

Vaccines - we spoke about vaccines. Yes, we are rebuilding a very strong momentum with new launches for the future but also with higher investments to be sure. That will be ready to be in front of the market for the vaccines.

Yes, it's strong growth, sustainable growth rate. It's two areas. The most important area perhaps is research. Gerard give you the last information, the last six information in the results. And we spoke only on Phase IIb and III because we will continue to be like in the past, we are not here for dreaming, we are here for delivering. And as soon as we are not in IIb or III, we think that it's more dream than delivering. So, yes, it's impressive even for us, on seven results to have only one negative result.

The second part of the sustainable growth is to be sure that we are pushing the pole on the field, and we are pushing the pole on the field. If you look at what we are doing in China, what we are doing in the south, but also what we are doing in the States or what we are doing in Europe, I think that the future and the sustainable growth of the Company is in the hands of the field -- the teams on the field, and we continue to improve these teams. We continue to improve the number of the people, and we continue to improve the pace and the quality of the people. Another reason why we have so good a result.

So we are in sustainable growth in our mind clearly. I think that I don't go back to these figures, you know that. Gerard explained all these figures also and, yes, profitable growth, which from my view is a very profitable growth.

I think that all what we said, all what Jean-Claude said about the gross margin, about the operating income, about the earnings per share. Yes, we say that we will be around 18%. We are at 26%. That's not something so easy and it's impressive, even for me. And that's the reason why we increased our full year guidance, saying that we will be at least 20%.

So I think that we had a very good first part of '05, and we will finish a good '05, I'm sure of that. So now, I think that we have to go to the questions naturally.

QUESTIONS AND ANSWERS

Operator

Thank you sir. [OPERATOR INSTRUCTIONS]. We pick up the question from Tim Anderson from Prudential Securities. Please go ahead.

Tim Anderson - Prudential Securities - Analyst

Thanks. I have a few questions on xaliproden. I know you are looking at prevention of severe PSN but if I look at your results in Grade 2, it looks like xaliproden patients, in fact, had a worsening of symptoms compared to placebo. And I guess in Grade 1 there was no difference in placebo, so I am wondering how you interpret those?

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

Second question is I know in the first meeting you had this morning, you were asked about what you would need to file on. And I also realize that this data is fresh. But I would imagine that all along the way here you had discussions with regulatory agencies, in terms of what exactly you would need for filing. So I am just hoping to get more clarity. Are you talking about maybe just one Phase III trial? Are you going to need to show the PFS data or what exactly? And then, with the standard of care in colorectal cancer changing, doesn't this represent a hurdle in achieving PFS in the FOLFOX4 patients?

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

No. In fact, there is no worsening of Grade 2 PSN. In fact, if you -- it's a relative percentage. So if you decrease the Grade 3, the percentage of Grade 3 PSN with xaliprodin, that is to say that patients who were supposed to have Grade 3 PSN, in fact have Grade 2 PSN. So it's not a worsening, it's a relative percentage. So for sure xaliprodin never [indiscernible] so-called Grade 2 PSN.

And concerning the filing, as you understood, we are -- we discussed the results very simply. So we'll have to discuss with the authority, in order to see what they will need with a potential filing. And again, we are quite happy on these reasons for two reasons.

The first reason is for sure for oncology, that is to say we decrease the side effects of oxaliplatin. That is to say that possibly we can increase the number of cycles with oxaliplatin. So if it is the case oxaliplatin will be more efficient in association with xaliprodin.

And secondly, and maybe as important, is a kind of proof of concept showing that xaliprodin in humans, by oral route once a day, 1 milligram, is as neuro-protective activity. But again, too early to say when we'll file with these results and what will be the questions of the authorities. Really, I can't answer this question.

Tim Anderson - Prudential Securities - Analyst

Okay. And then the last question about standard of care in colorectal cancer changing?

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

Yes, right now, right now we do it with oxaliplatin but possibly we'll do it in association with other compounds, as you know. So maybe we can do it with, let's say, a biological compound in association with oxaliplatin. We can do everything you can think about, but right now here are the data we have. But possibly we will do it. Again, too early to say.

Tim Anderson - Prudential Securities - Analyst

Okay. And then the last question is the study of PSN well validated from a clinical development standpoint, in terms of what exactly you need to measure?

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

I don't understand the question.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

Tim Anderson - Prudential Securities - Analyst

Well, when you measure efficacy of a disease, in certain cases they have been well validated in other either clinical or animal models, from a regulatory perspective. So I am wondering, in this case, in the case of PSN, if regulatory authorities have basically said, well, here's exactly what you need to deliver to show efficacy in PSN.

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

Again, it's not a direct activity on PSN. It's just to try to antagonize the worsening of the PSN induced by chemotherapy. It's not to test this compound in PSN. Again, one more time, possibly we will do it. But right now, we don't have in mind to do so.

Tim Anderson - Prudential Securities - Analyst

Yes. Okay, thank you.

Operator

Thank you. We will take our next question from Michael Leacock from Nomura. Please go ahead.

Michael Leacock - Nomura - Analyst

Thank you. I have a couple of questions, if I may, for Dr. Le Fur. Firstly, on Alvocidib, certainly some interesting data you've presented. This is a new dosage regimen. Is that the only dosage regimen you will now pursue or are you looking at a range of further dosage regimens?

Secondly, I gather with the Lysis Syndrome you say it's coming early. I think in some reports it's at the first dose of the product. Does this perhaps pose even more challenge for managing such side effects? When will the survival data be mature for your open label study?

And then, if I may, more simply on the smoking cessation product, 813, the abstinence rate in placebo seems quite low at around 7%. I gather the usual rate is more like 15% in the placebo group. I wonder if you have any comment about that? And also, did you see any weight gain with the product?

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

Well, concerning the regimen of, if I understood well, of the beta-3 agonist, we tested this BID administration because initially we did three times a day, we started with three times a day administration of the SR compound. But for sure we performed bio-equivalent activity and we showed that two times 350 milligram was quite similar to the three times administration. So that's why we did it, because we just would like to decrease the number of administrations per day.

Concerning Lysis Syndrome, again, it's possibly a surrogate marker showing efficacy. And as we already mentioned to you in the past and we launched rasburicase exactly for this clinical indication. So in other words, certainly in the Phase III study that we built up with this compound, and the Phase III study will be the only very important study we need. We'll certainly try to decrease Lysis Syndrome by using rasburicase, but again, it's just too early to say what will be the proper call. And we will discuss with NCI, in order to be in the best condition to see what is the effect of flavopiridol in these patients.

Concerning the low response rate under placebo, I'll just remind you that opposite to other clinical trials, I know this is the abstinence rate for the last four weeks. So it is to say very difficult to achieve. So that's why we got a low placebo response rate.

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

And you know, what is important is the difference in our condition and not by historical comparisons, to compare the effect of the compound, of the three doses in this case, versus placebo.

Moreover, again, the clinical efficacy was very high, as I mentioned to you, by biological marker. That is to say CO measurement and cutting plasma levels. So it's certainly part of the explanation of the so-called low placebo activity in this clinical trial.

Michael Leacock - *Nomura - Analyst*

Thank you.

Operator

Thank you. Our next question comes from Jo Walton from Lehman Brothers. Please go ahead.

Jo Walton - *Lehman Brothers - Analyst*

Two quick questions please. Concerning the cost savings, you say that you have taken cost savings perhaps earlier than expected and that most of the work will have been completed by the middle of next year. Presumably the payoff for some of that work will, however, take some time to come through, things like manufacturing savings, etc., which take a while to come through. Do you have any feel for what the ultimate peak cost savings may now be? Presumably they will be higher than they were before.

And secondly, is there any impact yet in your numbers for pre-launch costs for Acomplia?

Jean-Claude Leroy - *Sanofi Aventis - SVP & CFO*

Okay. At least I'll take the first one on the cost saving. When we mentioned that we would -- we were going faster than anticipated, then Jean-Francois Dehecq said that the end of the program would be the end -- the middle of '06 rather than the end of '06, what he was mentioning is that we would reach the, I would say, the peak level on a cumulative basis quicker than anticipated. Now, that being said, and let's be clear about that, more than 75% on a cumulative basis end of '05 to reach obviously quickly the total, the 1.6b is one part of the answer.

Now, you are talking about is there any additional in the future manufacturing and so on to come up to a new peak. I'll remind you that when we described the kind of synergies, even though we didn't give any precise figures on the components of the 1.6b, we said from day one that manufacturing was a very, very small part of that 1.6b. And for good reasons, which are still valid. You know very well what is the impact or the weight of the manpower in the cost of sales, and what it is compared to the -- as a percentage to the sales level. You know that on a financial basis we are talking of nothing. So that's the reason for which we didn't include that in our program. That's the first part of it because that's not the way you make savings.

In addition to that, because this is not the only answer on that manufacturing part of it, you know that we've been basing a large part of our growth, I mean on the synergies, on the growth, on the positive growth of it. And you know, and I mentioned that in already in the first half of the year-end, it is true also at the end of this year, that we are in advance as compared to the market. We are much more in advance as we were last year. That does mean a lot more activity. And also, because it is made on the so-called tail business, it is a large part of the volume activity of the plants of the Company.

So what was probably at the zero, what could have been seen as something which has to be rationalized, is no more to be seen as something which is rationalized, just because we are increasing the volume of activity. So once again, I would say for strategic

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

reasons, just because it was part of the project, manufacturing was not on the screen. In addition to that, you know very well that on a financial measure, it doesn't bring a lot to the profitability of the Group.

So no, there are no additional unseen targets, additional targets to be taken into account. Maybe we will do some rationalization in the years to come. But that's not only for cost saving, it's for, I'd say, a lot of optimization reasons. If we do so in the future in the world, not especially in France or Europe, so we don't increase our target 1.6b. And again, there are -- there is not much of the manufacturing, I said purchasing policy, which is different, but not manufacturing per se.

Jo Walton - *Lehman Brothers - Analyst*

Can I ask what your overall staff numbers are as well, please, at the half-year?

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

Well, the global staff is obviously decreasing. As we said earlier, we don't give a precise figure. If you want to ask us if the effect of rationalization this quarter brings a negative effect on the global situation of the Group, I'd say yes, it's a decrease. If you ask me if there are more people in R&D, more people in the commercial, behind the product, the answer is also yes. If there are a lot more -- a lot less people at the headquarters, G&A so-called, I would say yes.

But it's -- the global answer is not the total answer. The answer is a little less probably, but what is to prepare the future is a plus, and what is to rationalize what is the normal result of a merger, yes, obviously there is a decrease. So it's a mix of both, so that we are in a position to develop the Company.

Hanspeter Spek - *Sanofi Aventis - EVP Pharmaceutical Operations*

Yes. Then on your questions around pre-marketing Acomplia. So what can I tell you, yes, as I said earlier, we are actively pre-marketing the product of course. So certainly I would like to give you perhaps two orientations. I would estimate that we have today about 200 FTEs worldwide active in the field force. So Acomplia [average] should not be misunderstood, of course they don't promote Acomplia but, say, promote the underlying conditions, [indiscernible] as cardiovascular metabolic risk and financial for us.

In terms of money, you know very well that we don't give precise figures, products related, but I would give you an estimate. I would say that in the first half our spendings, except clinical research, are below 100m in direct marketing expenses. Direct marketing expenses is our field force.

Jo Walton - *Lehman Brothers - Analyst*

Thank you very much.

Operator

Thank you. We will take our next question from [Kurt Schagenbert] from [River Edge Capital]. Please go ahead.

Kurt Schagenbert - *River Edge Capital - Analyst*

Yes, thank you. You said you expect Acomplia to be on the market by a year from now, but you filed it in the first quarter of '05. So why shouldn't you expect it to be approved by first quarter '06?

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

First of all, I'm sorry, we filed second quarter this year, not first quarter; second quarter this year. And if you add, let's say, nine months, have a look, let's take it in 2006. That's very classical.

Hanspeter Spek - Sanofi Aventis - EVP Pharmaceutical Operations

The American estimate would be yes, and in the second quarter of 2006, please keep in mind that the usual figure, you get the 12-month period. That does not include the so-called [DD MAG] negotiations, which means in the U.S. you have to submit all promotional material before to a subdivision which is called [DD MAG].

Under normal circumstances, this already takes between four and 12 weeks if you go up with a totally new molecule and you have a certain idea how this product should be communicated. You'd better estimate, let's say, ten weeks than four weeks. And, as you know, the European period is at least 12 months from a purely administrative point of view. But then, unfortunately, it is still European reality that each member state has to recognize the European decision, which unfortunately takes between, let's say, four weeks in Germany and up to 12 or 18 months in Belgium. And then, in certain markets, you even have another period of negotiating the reimbursement conditions.

Kurt Schagenbert - River Edge Capital - Analyst

Okay. Thank you.

Operator

Thank you. We will take our next question from Sachin Jain from Merrill Lynch. Please go ahead.

Sachin Jain - Merrill Lynch - Analyst

Good afternoon, gentlemen. It's Sachin Jain from Merrill Lynch. Two questions, if I may. Firstly, on Acomplia, I just wonder if you are able to provide further details on the Phase IIIb program, and just a broad overview of the size, when you started recruiting it and an approximate timeframe for the studies.

And then secondly, on Lovenox, I was just wondering if you could update us on your legal strategy, where you are in the appeal process and whether you are able to provide any color on how you will use the new patent in your defenses yet. Thank you.

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

So, concerning the lifecycle management with rimonabant, as you know, we have a new study starting or already started in diabetes, that is to say in a very -- in monotherapy because the so-called RIO-diabetes it was on top of all anti-diabetic agents. And we have a new study already started for monotherapy in type 2 diabetes.

We'll start another study with more parameters, which might be quite similar to RIO-Lipids, as we call it, [indiscernible] lipids, you will see. And we have also two studies in order to see what will be the benefit of -- the potential benefit of rimonabant on coronary arterial sclerosis, either for -- by using IMT techniques or by using [high-res] techniques.

And thirdly, and maybe even more important, we'll start very soon a very large morbimortality study on top of existing therapy, for the cardiovascular reach in the population, which is quite similar of the one we use in the dossier that we filed, with a two-year

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

follow up. That is to say that it will be a very huge study with, let's say, between 15,000 and 20,000 patients, two-years follow up. So we are currently doing and starting a very large lifecycle management with rimonabant, both in comorbidities with studies around diabetes associated with obese patients and also with hyperlipidemia. And again, more important, three studies in the -- for the cardiovascular risk, which are very, very important.

Hanspeter Spek - Sanofi Aventis - EVP Pharmaceutical Operations

On Lovenox, you will understand that I cannot go too much into detail concerning our legal tactics but our strategy is two-fold. One axis is a purely legal strategy in defending our patents. You probably know that we have lost in the first instance but meanwhile we have filed appeals. This appeal will also integrate the extended patent, which wasn't subject to the first decision. The outcome of this by nature is totally open and we can give no orientation even on timing.

The second axis is that we basically challenge and see as totally in line with a citizens' petition which has been filed with the FDA, where the underlying assumption is being challenged that there could be made reference to the clinical file of Lovenox, in saying that generics of biological products would have to be handled as generics of, let's say, a synthetic product. We are convinced, we believe, and once again totally in line with this petition, that biological products are totally different from synthetic products.

This decision has been filed with the FDA. So far, the reaction of the FDA has not taken place. We believe it is imminent. But once again, it is in the hands of the authorities. We cannot say anything more. But our different strategy is two-fold and we believe we have a very good case in both directions.

Sachin Jain - Merrill Lynch - Analyst

Thank you.

Operator

Thank you. We will take our next question from Edmund Kim from JP Morgan. Please go ahead.

Edmund Kim - JP Morgan - Analyst

Thank you for taking my questions. I have two quick questions. In the analysts' meeting early this morning, it's my understanding that management made comments that it would be better prepared to discuss promotion next week. Can you elaborate on what next week means? Does that mean that the [indiscernible] and the final label negotiations, what gives you confidence that launch is very, very imminent, as you stated earlier in this call?

Hanspeter Spek - Sanofi Aventis - EVP Pharmaceutical Operations

I would make reference to what my friend Gerard said before. Gerard said we are confident that we launch the product before the end of the summer and next week is well before the end of the summer. So please take it cryptically, as it is being said.

Edmund Kim - JP Morgan - Analyst

Thank you. And secondly, Sanofi had also indicated early in the morning that it would be competitive on length of usage, the maintenance and price. So given those comments, do you expect to receive a maintenance claim as measured by WASO at eight hours?

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi Aventis - EVP Pharmaceutical Operations

We have requested this and yes, of course, we are confident.

Edmund Kim - JP Morgan - Analyst

Great. Thank you.

Operator

Thank you. [OPERATOR INSTRUCTIONS]. We take our next question from Elizabeth Mitchell from MainFirst. Please go ahead.

Elizabeth Mitchell - MainFirst - Analyst

Hello. My question is about the stopping more recruitment to the Amadeus by comparing that to trial. Could you tell me, first of all, in terms of the study design, why didn't you just in the first place have the same number of patients in the clapidogrel trial as in the idraparinux trial?

And secondly, why did you decide actually not to double the number of patients in it, because it seems to me it's actually quite cheap to recruit patients for that type of study?

And finally, just as an option, couldn't -- to get more events, couldn't you just carry the study on longer? If you wait long enough, you would get more events.

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

Again, it's always difficult to choose when you have such a proposal. First of all, I would say fortunately for the patient, apparently right now people are very well treated in atrial fibrillation when we tried to see whether they are even associated with thromboembolism.

The number of patients, when you have to double the number of patients, it's really a little bit complicated to go on and to decide to do so. Because you know it is a proposal from the steering committee and if you consider in the active trial, the increase of 1,500 patients is roughly a little bit between 10 to 15%, which is not too much. But to double the number of patients is quite complicated to manage. And for that reason, we believe that it's more interesting for the Company to decide to not to double the number of patients, because that means that possibly the study will be futile. So that is to say that we will be unable to detect any difference. So for all these reasons, it's certainly very difficult to double the size of a study, never.

Elizabeth Mitchell - MainFirst - Analyst

But why were the numbers of patients not similar in the first place? Therefore, you know you are going to get similar statistical significance.

Gerard Le Fur - Sanofi Aventis - SEVP, Science & Medical Affairs

Well, keep in mind this is a proposal from the steering committee but maybe it's in the wrong way. So when you decide to double the size, this does not mean that you will be sure to be, let's say, to reach the primary endpoint. So we had the feeling that with such a huge increase in patients, maybe it's a little bit too risky and it will take quite a lot of time to do so.

FINAL TRANSCRIPT

Aug. 31. 2005 / 9:00AM, SNY - Q2 2005 Sanofi-Aventis Earnings Conference Call

For all these reasons, and the steering committee agree, we decided not to follow this proposal, which was only a proposal. And we had to choose and we decided to do it with the clopidogrel group. I'll just remind you that in the so-called Van Gogh, the three other Phase III studies, apparently all the patients are recruited. And apparently we have enough, let's say, events in order to possibly see a difference between idraparinux and the reference compound.

So for that reason, we prefer to stop the recruitment and we'll see with the patients we have right now, which are close to 5,000 patients, whether we can find -- reach the primary endpoint or not.

Elizabeth Mitchell - *MainFirst - Analyst*

Okay. Thank you very much.

Operator

Thank you. Gentlemen, we don't have any further questions.

Jean-Francois Dehecq - *Sanofi Aventis - Chairman & CEO*

So thank you very much for your time and see you soon.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2005, Thomson Financial. All Rights Reserved.

Exhibit K

**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION**
Washington, D.C. 20549

FORM 20-F

(Mark One)

☐ REGISTRATION STATEMENT PURSUANT TO SECTION 12(b) OR (g) OF THE SECURITIES EXCHANGE ACT OF 1934
OR

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2005

OR

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
OR

☐ SHELL COMPANY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

Date of event requiring this shell company report

For the transition period from to

Commission File Number: 001-31368

Sanofi-Aventis

(Exact name of registrant as specified in its charter)

N/A

(Translation of registrant's name into English)

France

(Jurisdiction of incorporation or organization)

174, avenue de France, 75013 Paris, France

(Address of principal executive offices)

Securities registered or to be registered pursuant to Section 12(b) of the Act:

Title of each class:	Name of each exchange on which registered:
American Depositary Shares, each representing one half of one ordinary share, par value €2 per share	New York Stock Exchange
Ordinary shares, par value €2 per share	New York Stock Exchange (for listing purposes only)

Securities registered pursuant to Section 12(g) of the Act:

American Depositary Shares, each representing one quarter of a Participating Share Series A, par value €70.89 per share (removed from listing and registration on the New York Stock Exchange effective July 31, 1995).

The number of outstanding shares of each of the issuer's classes of capital or
common stock as of December 31, 2005 was:

ordinary shares: 1,401,306,569

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405
of the Securities Act.

YES ☒ NO ☐

If this report is an annual or transition report, indicate by check mark if the registrant is not
required to file reports pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934.

YES ☐ NO ☒

Note — Checking the box above will not relieve any registrant required to file reports pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 from their obligations under those Sections.

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒

Accelerated filer ☐

Non-accelerated filer ☐

Indicate by check mark which financial statement item the registrant has elected to follow.

Item 17 ☐ Item 18 ☒

If this is an annual report, indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

YES ☐ NO ☒

PRESENTATION OF FINANCIAL AND OTHER INFORMATION

The consolidated financial statements contained in this annual report on Form 20-F have been prepared in accordance with International Financial Reporting Standards (“IFRS”) adopted by the European Union as of December 31, 2005 and with IFRS issued by the International Accounting Standards Board (“IASB”) as of the same date. IFRS differ in certain significant respects from U.S. generally accepted accounting principles (“U.S. GAAP”). For a description of the principal differences between IFRS and U.S. GAAP, as they relate to us and to our consolidated subsidiaries, and for a reconciliation of our shareholders’ equity and net income to U.S. GAAP, see Note G to our consolidated financial statements included at Item 18, of this annual report.

Our results of operations and financial condition as of and for the year ended December 31, 2004 and have been significantly affected by our August 2004 acquisition of Aventis and certain subsequent transactions (including the merger of Aventis with and into our Company in December 2004). The results of operations of Aventis for the period between August 20, 2004 and December 31, 2004 have been included in our consolidated income statement and cash flow statement. This resulted in a significant increase in revenues and significant changes in other financial statement items in 2004 compared to 2003. The assets and liabilities of Aventis are also included in our consolidated balance sheet at December 31, 2004. See “Item 5. Operating and Financial Review and Prospects.”

We have prepared unaudited pro forma income statements for 2004 that present our results of operations as if the acquisition had taken place on January 1, 2004, described under “Item 5. Operating and Financial Review and Prospects.” Because of the significance of the Aventis acquisition, we present certain 2004 financial information in this annual report, such as sales of particular pharmaceutical products, as a percentage of our unaudited pro forma sales, rather than as a percentage of our consolidated sales.

Unless the context requires otherwise, the terms “sanofi-aventis,” the “Company,” the “Group,” “we,” “our” or “us” refer to sanofi-aventis and our consolidated subsidiaries. References to “Aventis” refer to Aventis and its consolidated subsidiaries for periods prior to August 20, 2004.

All references herein to “United States” or “U.S.” are to the United States of America, references to “dollars” or “\$” are to the currency of the United States, references to “France” are to the Republic of France, and references to “euro” and “€” are to the currency of the European Union member states (including France) participating in the European Monetary Union.

Brand names appearing in this annual report are trademarks of sanofi-aventis and/or its affiliates, with the exception of:

- trademarks used or that may be or have been used under license by sanofi-aventis and /or its affiliates, such as Actonel®, Optinate® and Acrel®, trademarks of Procter & Gamble Pharmaceuticals, Alvesco®, a trademark of Altana Pharma AG, Campto®, a trademark of Kabushiki Kaisha Yakult Honsha, Copaxone®, a trademark of Teva Pharmaceutical Industries, Exubera®, a trademark of Pfizer Products Inc., Genasense®, a trademark of Genta Inc in the United States, Tavanic®, a trademark of Daiichi Pharmaceutical Co. Ltd., Mutagrip®, a trademark of Institut Pasteur, Gardasil®, a trademark of Merck & Co., Inc., Herceptin®, a trademark of Genentech, NanoCrystal®, a trademark of Elan Pharmaceuticals, Uvidem®, a trademark of Immuno Design Molecule (IDM), Inc.;
 - trademarks sold by sanofi-aventis and/or its affiliates, such as Altace®, a trademark of King Pharmaceuticals in the United States, Arixta® and Fraxiparine®, trademarks of GlaxoSmithKline, Cardizem®, a trademark of Biovail in the United States, StarLink®, a trademark of Bayer AG, Sabril®, a trademark of Ovation Pharmaceuticals in the United States;
 - Cipro® in the U.S. and Aspirin®, trademarks of Bayer AG, Ivomec®, Eprinex®, Frontline® and Heartgard®, trademarks of Merial and Hexavac®, a trademark of Sanofi Pasteur MSD.
-

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report contains forward-looking statements. We may also make written or oral forward-looking statements in our periodic reports to the Securities and Exchange Commission on Form 6-K, in our annual report to shareholders, in our proxy statements, in our offering circulars and prospectuses, in press releases and other written materials and in oral statements made by our officers, directors or employees to third parties. Examples of such forward-looking statements include:

- projections of operating revenues, net income, adjusted net income, earnings per share, adjusted earnings per share, capital expenditures, positive or negative synergies, dividends, capital structure or other financial items or ratios;
- statements of our plans, objectives or goals, including those relating to products, clinical trials, regulatory approvals and competition;
- statements about our future economic performance or that of France, the United States or any other countries in which we operate; and
- statements of assumptions underlying such statements.

Words such as “believe,” “anticipate,” “plan,” “expect,” “intend,” “target,” “estimate,” “project,” “predict,” “forecast,” “guideline,” “should” and similar expressions are intended to identify forward-looking statements but are not the exclusive means of identifying such statements.

Forward-looking statements involve inherent risks and uncertainties. We caution you that a number of important factors could cause actual results to differ materially from those contained in any forward-looking statements. Such factors, some of which are discussed under “Risk Factors” below, include but are not limited to:

- the impact of our acquisition of Aventis;
- our ability to continue to maintain and expand our presence profitably in the United States;
- the success of our research and development programs;
- our ability to protect our intellectual property rights;
- the risks associated with reimbursement of healthcare costs and pricing reforms, particularly in the United States and Europe; and
- trends in the exchange rate and interest rate environments.

We caution you that the foregoing list of factors is not exclusive and that other risks and uncertainties may cause actual results to differ materially from those in forward-looking statements.

Forward-looking statements speak only as of the date they are made. Other than required by law, we do not undertake any obligation to update them in light of new information or future developments.

TABLE OF CONTENTS

Part I		
Item 1.	Identity of Directors, Senior Management and Advisers	1
Item 2.	Offer Statistics and Expected Timetable	1
Item 3.	Key Information	1
	A. Selected Financial Data	1
	B. Capitalization and Indebtedness	3
	C. Reasons for Offer and Use of Proceeds	3
	D. Risk Factors	3
Item 4.	Information on the Company	13
	A. History and Development of the Company	14
	B. Business Overview	16
	C. Organizational Structure	62
	D. Property, Plant and Equipment	63
Item 5.	Operating and Financial Review and Prospects	66
Item 6.	Directors, Senior Management and Employees	96
	A. Directors and Senior Management	96
	B. Compensation	107
	C. Board Practices	109
	D. Employees and profit sharing	110
	E. Share ownership	113
Item 7.	Major Shareholders and Related Party Transactions	115
	A. Major Shareholders	115
	B. Related Party Transactions	116
	C. Interests of Experts and Counsel	117
Item 8.	Financial Information	118
	A. Consolidated Statements and Other Financial Information	118
	B. Significant Changes	121
Item 9.	The Offer and Listing	122
	A. Offer and Listing Details	122
	B. Plan of Distribution	122
	C. Markets	123
	D. Selling Shareholders	124
	E. Dilution	124
	F. Expenses of the Issue	124
Item 10.	Additional Information	125
	A. Share Capital	125
	B. Memorandum and Articles of Association	125
	C. Material Contracts	139
	D. Exchange Controls	140
	E. Taxation	140
	F. Dividends and Paying Agents	146
	G. Statement by Experts	146
	H. Documents on Display	146
	I. Subsidiary Information	146
Item 11.	Quantitative and Qualitative Disclosures about Market Risk	146
Item 12.	Description of Securities other than Equity Securities	149
Part II		
Item 13.	Defaults, Dividend Arrearages and Delinquencies	150
Item 14.	Material Modifications to the Rights of Security Holders	150
Item 15.	Controls and Procedures	150
Item 16.	[Reserved]	150
Item 16 A.	Audit Committee Financial Expert	150
Item 16 B.	Financial Code of Ethics	150
Item 16 C.	Principal Accountants' Fees and Services	151
Item 16 D.	Exemptions from the Listing Standards for Audit Committees	152
Item 16 E.	Purchases of Equity Securities by the Issuer and Affiliated Purchasers	152
Part III		
Item 17.	Financial Statements	153
Item 18.	Financial Statements	154
Item 19.	Exhibits	272

PART I

Item 1. Identity of Directors, Senior Management and Advisers

N/A

Item 2. Offer Statistics and Expected Timetable

N/A

Item 3. Key Information

A. Selected Financial Data

SUMMARY SELECTED FINANCIAL DATA

The tables below set forth selected consolidated financial data for sanofi-aventis. These financial data are derived from the sanofi-aventis consolidated financial statements. Sanofi-aventis financial statements for the years ended December 31, 2005 and 2004 are included in Item 18 of this annual report.

The consolidated financial statements of sanofi-aventis for the year ended December 31, 2005 have been prepared in compliance with IFRS adopted by the European Union as of December 31, 2005 and with the IFRS issued by the International Accounting Standards Board (IASB) as of the same date. The term "IFRS" refers collectively to International Accounting Standards (IAS), International Financial Reporting Standards (IFRS), Standing Interpretations Committee (SIC) interpretations and International Financial Reporting Interpretations Committee (IFRIC) issued by the IASB. The opening balance sheet as of the transition date (January 1, 2004) and the comparative financial statements for the year ended December 31, 2004 have been prepared in accordance with the same principles.

Sanofi-aventis reports its financial results in euro and in conformity with IFRS, with a reconciliation to U.S. GAAP. Sanofi-aventis also publishes condensed U.S. GAAP information. A description of the principal differences between IFRS and U.S. GAAP as they relate to the sanofi-aventis consolidated financial statements are set forth in Note G to the sanofi-aventis audited consolidated financial statements included in this annual report.

SELECTED CONDENSED FINANCIAL INFORMATION

(in millions of euro, except per share data)	As of and for the year ended December 31,				
	2001	2002	2003	2004	2005
IFRS Income statement data:					
Net sales	—	—	—	14,871	27,311
Gross profit	—	—	—	11,294	20,947
Operating income	—	—	—	2,426	2,888
Net income	—	—	—	1,986	2,258
Earnings per share: basic (a)	—	—	—	2.18	1.69
Earnings per share: diluted (b)	—	—	—	2.17	1.68
IFRS Balance sheet data:					
Intangible assets	—	—	—	33,229	30,229
Total assets	—	—	—	85,407	86,658
Long-term debt	—	—	—	8,654	4,750
Equity attributable to equity holders of the company	—	—	—	41,061	46,637
U.S. GAAP Data: (e)					
Revenues from sale of products	6,069	7,448	8,048	14,871	27,311
Gross profit	4,843	6,163	6,718	11,293	20,946
Operating profit (loss)	1,715	2,301	2,797	(2,999)	2,816
Net income (loss)	1,098	1,640	1,865	(3,665)	2,202
Earnings (loss) per share: basic (c)	1.52	2.30	2.71	(4.03)	1.65
Earnings (loss) per share: diluted (d)	1.51	2.28	2.70	(4.03)	1.64
Intangible assets	5,178	5,140	4,553	32,858	28,699
Total assets	18,232	17,362	17,424	82,846	86,241
Long-term debt	119	65	53	8,638	4,734
Equity attributable to equity holders of the company	12,749	12,599	12,736	41,632	46,403
Cash dividend paid per share (f)	0,66	0,84	1,02	1,20	—

- (a) Based on the weighted average number of shares outstanding in each period used to compute basic earnings per share, equal to 910.3 million shares in 2004 and 1,336.5 million shares in 2005.
- (b) Based on the weighted average number of shares outstanding in each period used to compute diluted earnings per share, equal to 914.8 million shares in 2004 and 1,346.5 million shares in 2005.
- (c) Based on the weighted average number of shares outstanding in each period used to compute basic earnings (loss) per share, equal to 720.7 million shares in 2001, 714.3 million shares in 2002, 689.0 million shares in 2003, 910.3 million in 2004, and 1,336.5 million in 2005.
- (d) Based on the weighted average number of shares outstanding in each period used to compute diluted earnings (loss) per share, equal to 725.7 million shares in 2001, 718.0 million shares in 2002, 691.1 million shares in 2003, 914.9 million in 2004, and 1,346.5 million in 2005.
- (e) Sanofi-aventis applied Statement of Financial Accounting Standard 142, Goodwill and Other Intangible Assets, as of January 1, 2002 and voluntarily adopted the fair value recognition provisions of Financial Accounting Standard 123, Accounting for Stock-Based Compensation, as of January 1, 2003. Certain data as of and for the year ended December 31, 2004 have been reclassified to conform to the presentation adopted under IFRS with respect to joint ventures that are no longer accounted for under the proportionate consolidation method.
- (f) Each American Depositary Share, or ADS, represents one half of one share.

EXCHANGE RATE INFORMATION

Exchange Rates

The following table sets forth, for the periods and dates indicated, certain information concerning the exchange rates for the euro from 2001 through March 28, 2006 expressed in U.S. dollar per euro. The information concerning the U.S. dollar exchange rate is based on the noon buying rate in New York City for cable transfers in foreign currencies as certified for customs purposes by the Federal Reserve Bank of New York (the "Noon Buying Rate"). We provide the exchange rates below solely for your convenience. We do not

represent that euros were, could have been, or could be, converted into U.S. dollars at these rates or at any other rate. For information regarding the effect of currency fluctuations on our results of operations, see Item 5. "Operating and Financial Review and Prospects."

Selected Exchange Rate Information

	Period- end Rate	Average Rate ⁽¹⁾	High	Low
	(U.S. dollar per euro)			
2001	0.89	0.89	0.95	0.84
2002	1.05	0.95	1.05	0.86
2003	1.26	1.14	1.26	1.04
2004	1.35	1.25	1.36	1.18
2005	1.18	1.24	1.35	1.17
Last 6 months				
2005				
September	1.21	1.22	1.25	1.20
October	1.20	1.20	1.21	1.19
November	1.18	1.18	1.21	1.17
December	1.18	1.19	1.20	1.17
2006				
January	1.22	1.21	1.23	1.20
February	1.19	1.19	1.21	1.19
March 1st to 28th	1.21	1.20	1.22	1.19

(1) The average of the Noon Buying Rates on the last business day of each month during the relevant period for year average, on each business day of the month for monthly average.

On March 28, 2006 the Noon Buying Rate was \$1.2078 per euro.

B. Capitalization and Indebtedness

N/A

C. Reasons for Offer and Use of Proceeds

N/A

D. Risk Factors

Important factors that could cause actual financial or operating results to differ materially from expectations are disclosed in this annual report, including without limitation the following risk factors and the factors described under "Cautionary Statement Regarding Forward-Looking Statements." In addition to the risks listed below, we may be subject to other material risks that are not currently known to us or that we deem immaterial at this time

Risks Relating to Our Company

The integration of the new Group's activities presents significant challenges that may result in the combined business not operating as effectively as expected or in the failure to achieve some or all of the anticipated benefits of the business combination.

The benefits and synergies expected to result from the combination of sanofi-aventis and Aventis will depend in part on whether the operations of Aventis can be integrated in a timely and efficient manner with those of sanofi-aventis. Sanofi-aventis faces significant challenges in consolidating sanofi-aventis' functions with those of Aventis, and integrating the organizations, procedures and operations of the two businesses. The integration of the two businesses is complex and time-consuming, and management must dedicate substantial time and resources to it. These efforts could divert management's focus and resources from other strategic opportunities and from day-to-day operational matters during the integration process. Failure to integrate successfully the

operations of sanofi-aventis and Aventis could result in delay or the failure to achieve some or all of the anticipated benefits from the business combination, including synergies and other operating efficiencies, and could have an adverse effect on our business, operating results, financial condition or prospects.

We incurred substantial debt in connection with the acquisition of Aventis, which limits our business flexibility and requires us to devote cash resources to debt service payments.

In connection with our acquisition of Aventis, our consolidated debt increased substantially, because we incurred new debt to finance the cash portion of the acquisition consideration, and because our consolidated debt includes the debt incurred by Aventis prior to the acquisition. As of December 31, 2005, our net consolidated debt (financial debt less cash and cash equivalents and short term investments) was €9.9 billion, compared to a positive consolidated net cash position of €2.4 billion as of December 31, 2003, prior to the acquisition of Aventis. We make significant debt service payments to our lenders and our current debt level could restrict our ability to engage in additional transactions or incur additional indebtedness. For more information on our debt, please see “Item 5. Operating and Financial Review and Prospectus — Liquidity and Capital Resources” in this annual report.

We depend on the United States market for a significant part of our current and future operating results. A failure to continue our strategy of profitable operations in that market could adversely affect our business, results of operations, financial condition or prospects.

We may not achieve our growth strategy if we do not maintain and continue to expand profitably our presence in the United States, the world’s largest pharmaceuticals market. We have identified the United States, which accounted for approximately 35% of our net sales in 2005, as a potential major source of continued future growth and plan to capitalize on our direct presence in the United States in the coming years to build our leadership in this market. We face a number of challenges in maintaining profitable growth in the United States, including:

- The success of the management organization that we have established in the United States.
- The targeting of new products and customer markets.
- The fact that the United States market is dominated by major U.S. pharmaceutical companies.
- Slower growth of the U.S. pharmaceutical market.
- Aggressive generic competition.
- Potential changes in health care reimbursement policies and possible cost control regulations in the United States, including possible unfavorable developments in coverage of prescription drugs by Medicare.
- Increased FDA demands, leading to a potentially longer, more costly and more restrictive approval process.
- Heightened scrutiny of the pharmaceutical industry by the public and the media.
- Exposure to the euro-dollar exchange rate.

We depend on third parties for the marketing of some of our products. These third parties may act in ways that could harm our business.

We commercialize some of our products in collaboration with other pharmaceutical companies. For example, we currently have a major collaborative arrangement with Bristol-Myers Squibb for the marketing of Plavix® and Aprovel® in the United States and several other countries, and co-marketing agreements with Procter & Gamble Pharmaceuticals for the osteoporosis treatment Actonel® and Teva for Copaxone®, as well as an agreement with Merck & Co., Inc. for the distribution of vaccines in Europe. We also have alliances with several Japanese companies for the marketing of our products in Japan. See “Item 4. Information on the Company — Business Overview — Markets — Marketing and Distribution.” When we commercialize our products through collaboration arrangements, we are subject to the risk that certain decisions, such as the establishment of budgets and promotion strategies, are subject to the control of our collaboration partners, and that deadlocks may adversely affect the activities conducted through the collaboration arrangements. For

example, our alliances with Bristol-Myers Squibb (BMS) are subject to the operational management of BMS in some countries, including the United States. We cannot be certain that our partners will perform their obligations as expected. Further, our partners might pursue their own existing or alternative technologies or product candidates in preference to those being developed or marketed in collaboration with us.

The manufacture of our products is technically complex, and supply interruptions, product recalls or inventory losses caused by unforeseen events may reduce sales, delay the launch of new products and adversely affect our operating results and financial condition.

Many of our products are manufactured using technically complex processes requiring specialized facilities, highly specific raw materials and other production constraints. Our vaccine products in particular are subject to the risk of manufacturing stoppages or the risk of loss of inventory because of the difficulties inherent to the sterile processing of biological materials and the potential for the unavailability of adequate amounts of raw materials meeting our standards. The complexity of these processes as well as strict company and government standards for the manufacture of our products subject us to production risks. The occurrence or suspected occurrence of out-of-specification production can lead to lost inventories, and in some cases product recalls, with consequential reputational damage and the risk of product liability (See “— Product liability claims could adversely affect our business, results of operations and financial condition,” below). The investigation and remediation of any identified problems can cause production delays, substantial expense, lost sales and the delay of new product launches.

We depend on third parties for the manufacture and supply of a substantial portion of our raw materials, specialized components, active ingredients and medical devices.

Availability of Raw Materials and Specialized Components. Third parties supply us with a substantial portion of our raw materials and specialized components. Some raw materials and specialized components essential to the manufacture of our products are not widely available from sources we consider reliable — for example, there is a limited number of approved suppliers of heparins, which are used in the manufacture of Lovenox®. See “Item 4 Information on the Company — Business Overview — Production and Raw Materials” for a description of these outsourcing arrangements.

Third-Party Manufacturing of Active Ingredients. Although our general policy is to manufacture the active ingredients for our products ourselves, we subcontract the manufacture of some of our active ingredients to third parties, which exposes us to the risk of a supply interruption in the event that our suppliers experience financial difficulties or are unable to manufacture a sufficient supply of our products. The manufacture of the active ingredients for Eloxatine® and Xatral® and part of the manufacture of the active ingredient for Stilnox® is currently carried out by third parties, as are some of the manufacturing steps in the production of Lovenox®. Additionally, under our collaborative arrangement with BMS, pharmaceutical production of Plavix® and Aprovel® is conducted partly in sanofi-aventis plants and partly in BMS plants.

Third-Party Supply of Medical Devices. Medical devices related to some of our products, such as certain pens used to dispense insulin, are manufactured by third parties. Reliance on third parties exposes us to the risk of supply interruptions, including as a result of third-party manufacturing problems, as well as the risk of product liability for materials not produced by the Group. See “— Product liability claims could adversely affect our business, results of operations and financial condition,” below.

If disruptions or quality concerns were to arise in the third-party supply of raw materials, specialized components, active ingredients or devices, this would affect our ability to sell our products in the quantities demanded by the market and could damage our reputation and relationships with our customers. See also “— The manufacture of our products is technically complex, and supply interruptions, product recalls or inventory losses caused by unforeseen events may reduce sales, delay the launch of new products and adversely affect our operating results and financial condition,” above. Even though we aim to have backup sources of supply whenever possible, including by manufacturing backup supplies of our principal active ingredients at a second or third facility when practicable, we cannot be certain they will be sufficient if our principal sources become unavailable. Any of these factors could adversely affect our business, operating results or financial condition.

Our collaborations with third parties expose us to risks that they will assert intellectual property rights on our inventions or fail to keep our unpatented technology confidential.

We occasionally provide information and materials to research collaborators in academic institutions or other public or private entities, or request them to conduct tests to investigate certain materials. In all cases we enter into appropriate confidentiality and intellectual property rights agreements with such entities. However, those entities might assert intellectual property rights with respect to the results of the tests conducted by their collaborators, and might not grant licenses to us regarding their intellectual property rights on acceptable terms.

We also rely upon unpatented proprietary technology, processes, know-how and data that we regard as trade secrets and protect them in part by entering into confidentiality agreements with our employees, consultants and certain contractors. We cannot be sure that these agreements or other trade secret protections will provide meaningful protection, or, if they are breached, that we will have adequate remedies. You should read “Item 4. Information on the Company — Business Overview — Patents, Intellectual Property and Other Rights” for more information about our patents and licenses.

Claims relating to marketing practices could adversely affect our business, results of operations and financial condition.

The marketing of our products is heavily regulated, and failure to comply fully with applicable regulations could result in civil or criminal actions against us, and in some circumstances potential disqualification from participation in government health programs. Sanofi-aventis and certain of its subsidiaries are under investigation by various federal government entities in the United States, and are defendants in a number of lawsuits, relating to antitrust and/or pricing and marketing practices, including an investigation of suspected misrepresentations in product price data provided to U.S. federal health programs allegedly leading to inflated government reimbursements. See Note D.22(c) to our consolidated financial statements included at Item 18 of this annual report.

In addition, following judgments holding the U.S. patents covering DDAVP® tablets and Lovenox® to be unenforceable, a number of civil antitrust and fair trade claims have been filed against sanofi-aventis as putative class actions alleging that the Group has prevented competition and generated excess profits.

Because many of these cases allege substantial unquantified damages, including treble damages, and seek significant punitive damages and penalties, it is possible that any final determination of liability could have a material adverse effect on our business, results of operations or financial condition.

Fluctuations in currency exchange rates could adversely affect our results of operations and financial condition.

Because we sell our products in numerous countries, our results of operations and financial condition could be adversely affected by fluctuations in currency exchange rates. We are particularly sensitive to movements in exchange rates between the euro and the U.S. dollar, the British pound, the Japanese yen, and to a lesser extent to currencies in emerging countries. In 2005, approximately 35% of our net sales were realized in the United States. While we incur expenses in those currencies, the impact of currency exchange rates on these expenses does not fully offset the impact of currency exchange rates on our revenues. As a result, currency exchange rate movements can have a considerable impact on our earnings. When deemed appropriate, we enter into transactions to hedge our exposure to foreign exchange risks. These efforts, when undertaken, may fail to offset the effect of adverse currency exchange rate fluctuations on our results of operations or financial condition. For more information concerning our exchange rate exposure, see “Item 11. Quantitative and Qualitative Disclosures About Market Risk ”

Risks Relating to Our Industry

We must invest substantial sums in research and development in order to remain competitive, and we may not fully recover these investments if our products are unsuccessful in clinical trials or fail to receive regulatory approval.

To be successful in the highly competitive pharmaceutical industry, we must commit substantial resources each year to research and development in order to develop new products. In 2005, we spent €4,044 million on

research and development, amounting to approximately 14.8% of our net sales. Our ongoing investments in new product launches and research and development for future products could result in higher costs without a proportionate increase in revenues.

The research and development process is lengthy and carries a substantial risk of product failure. If our research and development does not yield sufficient new products that achieve commercial success, our future operating results may be adversely affected.

The research and development process typically takes from 10 to 15 years from discovery to commercial product launch. This process is conducted in various stages, and during each stage there is a substantial risk that we will not achieve our goals and will have to abandon a product in which we have invested substantial amounts.

For example, in order to develop a commercially viable product, we must demonstrate, through extensive pre-clinical and human clinical trials, that the pharmacological compounds are safe and effective for use in humans. There is also no assurance that favorable results obtained in pre-clinical trials will be confirmed by later clinical trials, or that the clinical trials will establish safety and efficacy data sufficient for regulatory approval. In the first quarter of 2006, we had 127 compounds in pre-clinical and clinical development in our targeted therapeutic areas, of which 55 were in phase II or phase III clinical trials. For additional information regarding clinical trials and the definition of the phases of clinical trials, see "Item 4. Information on the Company — Business Overview — Research and Development." There can be no assurance that any of these compounds will be proven safe or effective, or that they will produce commercially successful products.

After completing the research and development process, we must invest substantial additional resources with a view to obtaining government approval in multiple jurisdictions, with no assurance that approval will be obtained. We must obtain and maintain regulatory approval for our pharmaceutical products from the European Union, the United States and other regulatory authorities before a given product may be sold in these markets. The submission of an application to a regulatory authority provides no assurance that the regulatory authority will grant a license to market the product. Each authority may impose its own requirements, including requiring local clinical studies, and may delay or refuse to grant approval, even though a product has already been approved in another country.

In our principal markets, the approval process for one or more indications of a new product is complex and lengthy, and typically takes from six months to two years from the date of application depending on the country. Moreover, if regulatory approval of a product is granted, the approval may place limitations on the indicated uses for which it may be marketed. A marketed product is also subject to continual review even after regulatory approval. Later discovery of previously unknown problems may result in marketing restrictions or withdrawal of the product, as well as an increased risk of litigation. See also "— Product liability claims could adversely affect our business, results of operations and financial condition," below. In addition, we are subject to strict government controls on the manufacture, labeling, distribution and marketing of our products. Each of these factors may increase our costs of developing new products and the risk that we may not succeed in selling them successfully.

Obtaining regulatory marketing approval is not a guarantee that the product will achieve commercial success. Commercial success is dependent on a number of factors beyond our control, notably the level of reimbursement which is accorded to the product by public health entities and third-party payers, the acceptance of the product by the medical establishment and patients, and the existence and price of competing products and alternative therapies

If we are unable to protect our proprietary rights, we may fail to compete effectively or operate profitably.

It is important for our success that we be able to effectively obtain and enforce our patents and other proprietary rights. We currently have over 50,000 patents, patent licenses and patent applications worldwide. To the extent effective patent protection of our products is not maintained, these products will become exposed to competition from generic products. The entry of a generic product into the market typically is followed by a substantial decline in the brand-name product's sales volume and revenues.

Obtaining Patent Rights. Patent law relating to the scope of claims in the pharmaceutical field in which we operate is continually evolving and can be the subject of some uncertainty. Accordingly, we cannot be sure that:

- new, additional inventions will be patentable;
- patents for which applications are now pending will be issued or reissued to us; or
- the scope of any patent protection will be sufficiently broad to exclude competitors.

Patent protection once obtained is limited in time (typically 20 years), after which competitors may use the covered technology without obtaining a license from us. Because of the time required to obtain regulatory marketing approval, the period of effective patent protection for a marketed product is frequently substantially shorter.

Enforcing Patent Rights. Our competitors may infringe our patents or successfully avoid them through design innovation. To prevent infringement, we may file infringement claims, which are expensive and time consuming and which may result in decisions unfavorable to us. Policing unauthorized use of our intellectual property is difficult, and we may not be able to prevent misappropriation of our proprietary rights. We may also be accused of infringing the rights of others who then seek substantial damages from us. This risk is increased by the growth in the number of patent applications filed and patents granted in the pharmaceutical industry.

Even prior to the scheduled expiration of a patent, third parties may challenge the validity of the patents issued or licensed to us, which may result in the invalidation of these rights and the loss of sales derived from the related products. Such challenges have become increasingly common in recent years. Typical assertions in suits challenging a patent are that (i) the competing product does not fall within the scope of the patent, (ii) that the patent claims matters that are not in fact patentable, for example because they are not a true innovation; or (iii) that there were procedural flaws that invalidate the patent office's decision to issue the patent. Patent litigation is subject to substantial uncertainty, and we cannot be sure how much protection, if any, will be provided by our patents if we attempt to enforce them and they are challenged in court or in other proceedings.

Additionally, if a competitor chooses to take the risk of launching an infringing product prior to a court's determination that our patent rights are valid, enforceable and infringed, there can be no assurance (i) that we will be successful in obtaining a preliminary injunction to remove the infringing product from the market prior to obtaining a final injunction at trial, and (ii) that we will be able effectively to both obtain and collect sufficient damages from the competitor to repair all harm caused to us.

Significant challenges to our proprietary rights include:

Plavix®: In the first half of 2002, two pharmaceutical companies, Apotex and Dr. Reddy's Laboratories, each filed an Abbreviated New Drug Application (ANDA) with the U.S. Food and Drug Administration (FDA), seeking to market a purportedly generic form of Plavix® in the United States and challenging certain U.S. patents relating to Plavix®. Subsequently, in August 2004, Teva filed an ANDA challenging one of the U.S. patents relating to Plavix®. On January 24, 2006, we learned that the FDA had approved Apotex's ANDA. For additional information regarding ANDAs, see "Item 4. Information on the Company — Business Overview — Regulation." We have filed suit against Apotex, Dr. Reddy's Laboratories and Teva for infringement of our patent rights. See "Item 8 Financial Information — Consolidated Financial Statements and Other Financial Information — Information on Legal and Arbitration Proceedings" and Note D.22(b) to our consolidated financial statements included in this annual report at Item 18. The Plavix® patent rights are material to our business, and if we were unsuccessful in asserting them or they were deemed invalid, any resulting introduction of a generic version of Plavix® in the United States would reduce the price that we receive for this product and the volume of the product that we would be able to sell, and could materially adversely affect our business, results of operations and financial condition.

As a reference, the developed sales of Plavix® in 2005 in the United States amounted to €2,585 million out of total worldwide developed sales of sanofi-aventis for all products of €30,778 million. "Developed sales" is a non-GAAP financial measure we use to demonstrate the overall trends for our products in the market, and which consists of sales of our products, excluding sales to our alliance partners, and of sales that are made through our alliances but which are not included in our consolidated sales. In 2005, sanofi-aventis' share of the profits of the

Plavix® and Aprove® alliance entities managed by BMS in North America amounted to €404 million after taxes. See “Item 5. Operating and Financial Review and Prospects — Results of Operations — Year Ended December 31, 2005 Compared with Year Ended December 31, 2004” herein for additional information as well as a derivation of “developed sales.”

Allegra®: We have been notified that seven generic pharmaceutical companies are seeking FDA approval to market generic versions of Allegra® products in the United States. We have filed patent infringement lawsuits against all of these companies. Two of these companies, Barr and Teva, announced in September 2005, that they were launching their generic version of Allegra® immediately without first waiting for the judgment in the pending patent litigation. Although we continue to assert our patent rights against these companies, this generic launch has already resulted in a substantial decline in the Group’s sales of Allegra®, which dropped to €160 million in the last quarter of 2005 compared to €373 million in the last quarter of the preceding year.

Lovenox®: In June 2003, we were notified that both Amphastar Pharmaceuticals and Teva Pharmaceuticals were seeking approval from the FDA for purportedly generic versions of Lovenox® and are challenging the patent protection of this product. In June 2005, the U.S. District Court for the Central District of California granted Amphastar’s request for a summary judgment ruling our patent unenforceable on the grounds of inequitable conduct. Although we are appealing this decision, if we do not succeed in having the lower court decision overturned, we will no longer be able to assert our patent rights in the United States against purportedly generic versions of enoxaparin, the active ingredient of Lovenox®.

We are also involved in litigation challenging the validity or enforceability of patents related to a number of other products in the United States and the European Union, and challenges to other products may be expected in the future. We can give no assurance that as a result of these challenges we will not face generic competition for additional group products. See “Item 8. Financial Information — Consolidated Financial Statements and Other Financial Information — Information on Legal or Arbitration Proceedings” and Note D.22(b) to our consolidated financial statements included in this annual report at Item 18 for additional information.

Product liability claims could adversely affect our business, results of operations and financial condition.

Product liability is a significant commercial risk for us, and may become a more significant risk as we expand in the United States (where product liability claims can be particularly costly). Substantial damage awards have been made in certain jurisdictions against pharmaceutical companies based upon claims for injuries allegedly caused by the use of their products. Several pharmaceutical companies have recently recalled or withdrawn products from the market based on actual or suspected product risks, and currently face significant product liability claims. We are currently defending a number of product liability claims (see Note D.22 to the consolidated financial statements included at Item 18 of this annual report and “Item 8. Financial Information — Information on Legal or Arbitration Proceedings.”), and there can be no assurance that the Group will not face additional claims in the future. Although we maintain insurance to cover the risk of product liability, we cannot be certain that our insurance will be sufficient to cover all potential liabilities. Further, we face a general trend in the insurance industry to exclude certain products from coverage and to reduce insured limits for liabilities, causing companies to rely increasingly on self-insurance. Substantial product liability claims, if successful, could adversely affect our business, results of operations and financial condition.

Use of biologically derived ingredients may face consumer resistance, which could adversely affect sales and cause us to incur substantial costs.

In line with industry practice, we manufacture our vaccines and many of our prescription pharmaceutical products with ingredients derived from animal or plant tissue. Most of these products cannot be made economically, if at all, with synthetic ingredients. We subject our products incorporating these ingredients to extensive tests and believe them to be safe. There have been instances in the past where the use of biologically derived ingredients by sanofi-aventis or its competitors has been alleged to be an actual or theoretical source of harm, including infection or allergic reaction, or instances where production facilities have been subject to prolonged periods of closure because of possible contamination. Such allegations have on occasion led to damage claims and increased consumer resistance to such ingredients. A substantial claim of harm caused by a product incorporating biologically derived ingredients or a contamination event could lead us to incur potentially substantial costs as a result of, among other things, litigation of claims, product recalls, adoption of additional

safety measures, manufacturing delays, investment in consumer education, and development of synthetic substitutes for ingredients of biological origin. Such claims could also generate consumer resistance, with a corresponding adverse effect on sales and results of operations.

We face uncertainties over the pricing of pharmaceutical products.

The commercial success of our products depends in part on the conditions under which our products are reimbursed. Price pressure is strong due to:

- price controls imposed by governments in many countries;
- removal of a number of drugs from government reimbursement schemes; and
- the tendency of governments and private health care providers to favor generic pharmaceuticals.

Price pressure is considerable in our two largest markets, Europe and the United States, which represented approximately 44% and 35%, respectively, of our net sales in 2005. Changes in the pricing environments in the United States or Europe (on an individual country basis) could have a significant impact on our sales and results of operations. See “Item 4. Information on the Company — Business Overview — Pricing” for a description of certain regulatory pricing systems that affect our Group.

Our results may also be adversely affected by parallel imports, a practice by which traders exploit price differentials among markets by purchasing in lower-priced markets for resale in higher-priced markets.

Changes in the marketing status or competitive environment of our major products could adversely affect our results of operations.

In some cases, pharmaceutical products face the risk of being switched from prescription drug status to over-the-counter (OTC) drug status by national regulatory authorities. OTC drugs may not benefit from the same reimbursement schemes and are generally priced significantly lower than brand-name prescription drugs. The competitive environment for our products could also be adversely affected if generic or OTC versions of competitors’ products were to become available.

Risks from the handling of hazardous materials could adversely affect our results of operations.

Pharmaceutical manufacturing activities, such as the chemical manufacturing of the active ingredients in our products and the related storage and transportation of raw materials, products and wastes expose us to various risks, including:

- fires and/or explosions from inflammable substances;
- storage tank leaks and ruptures; and
- discharges or releases of toxic or hazardous substances.

These operating risks can cause personal injury, property damage and environmental contamination, and may result in:

- the shutdown of affected facilities and
- the imposition of civil or criminal penalties.

The occurrence of any of these events may significantly reduce the productivity and profitability of a particular manufacturing facility and adversely affect our operating results.

Although we maintain property, business interruption and casualty insurance that we believe is in accordance with customary industry practices, we cannot assure you that this insurance will be adequate to cover fully all potential hazards incidental to our business. For more detailed information on environmental issues, see “Item 4. Information on the Company — Business Overview — Health, Safety and Environment.”

Environmental liabilities and compliance costs may have a significant adverse effect on our results of operations.

The environmental laws of various jurisdictions impose actual and potential obligations on our Group to remediate contaminated sites. These obligations may relate to sites:

- that we currently own or operate;
- that we formerly owned or operated; or
- where waste from our operations was disposed.

These environmental remediation obligations could significantly reduce our operating results. In particular, our accruals for these obligations may be insufficient if the assumptions underlying these accruals prove incorrect or if we are held responsible for additional, currently undiscovered contamination. Sanofi-aventis accrues reserves for remediation when our management believes the need is probable and that it is reasonably possible to estimate the cost. These judgments and estimates may later prove inaccurate, and any shortfalls could have a material adverse effect on our results of operations. See “Item 4. Information on the Company — Business Overview — Health, Safety and Environment” for additional information regarding our environmental policies.

Furthermore, we are or may become involved in claims, lawsuits and administrative proceedings relating to environmental matters. Some current and former sanofi-aventis subsidiaries have been named as “potentially responsible parties” or the equivalent under the U.S. Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (also known as “Superfund”), and similar statutes in the United States, France, Germany, Brazil and elsewhere. As a matter of statutory or contractual obligation, we and/or our subsidiaries may retain responsibility for environmental liabilities at some of the sites our predecessor companies, or our subsidiaries that we demerged, divested or may divest. We are currently involved, for example, in litigation with Albemarle and Rhodia over environmental remediation at several sites no longer owned by the Group. An adverse outcome in any of these might have a significant adverse effect on our operating results. See Note D.22(e) to the consolidated financial statements included at Item 18 of this annual report.

Finally, stricter environmental, safety and health laws and enforcement policies could result in substantial costs and liabilities to our Group and could subject our handling, manufacture, use, reuse or disposal of substances or pollutants to more rigorous scrutiny than is currently the case. Consequently, compliance with these laws could result in significant capital expenditures as well as other costs and liabilities, thereby adversely affecting our business, results of operations or financial condition.

Risks Relating to an Investment in our Shares or ADSs

Foreign exchange fluctuations may adversely affect the U.S. dollar value of our ADSs and dividends (if any).

As a holder of ADSs, you may face exchange rate risk. Our ADSs trade in U.S. dollars and our shares trade in euro. The value of the ADSs and our shares could fluctuate as the exchange rates between these currencies fluctuate. If and when we do pay dividends, they would be denominated in euro. Fluctuations in the exchange rate between the euro and the U.S. dollar will affect the U.S. dollar amounts received by owners of ADSs upon conversion by the depository of cash dividends, if any. Moreover, these fluctuations may affect the U.S. dollar price of the ADSs on the New York Stock Exchange (NYSE), whether or not we pay dividends in addition to the amounts, if any, that you would receive upon our liquidation or upon the sale of assets, merger, tender offer or similar transactions denominated in euro or any foreign currency other than U.S. dollars.

If you hold ADSs rather than shares it may be difficult for you to exercise some of your rights as a shareholder.

As a holder of ADSs, it may be more difficult for you to exercise your rights as a shareholder than it would be if you directly held shares. For example, if we offer new shares and you have the right to subscribe for a portion of

them, the depositary is allowed, at its own discretion, to sell for your benefit that right to subscribe for new shares instead of making it available to you. Also, to exercise your voting rights, as a holder of ADSs, you must instruct the depositary how to vote your shares. Because of this extra procedural step involving the depositary, the process for exercising voting rights will take longer for you, as a holder of ADSs, than for holders of shares. ADSs for which the depositary does not receive timely voting instructions will not be voted at any meeting.

Our two largest shareholders own a significant percentage of the share capital and voting rights of sanofi-aventis.

At December 31, 2005, Total and L'Oréal, our two largest shareholders, held approximately 12.7% and 10.2% of our issued share capital, respectively, accounting for approximately 19.5% and approximately 17.4%, respectively, of the voting rights of sanofi-aventis. See "Item 7. Major Shareholders and Related Party Transactions — Major Shareholders — Shareholders' Agreement."

To the extent these shareholders continue to hold a large percentage of our share capital and voting rights, Total and L'Oréal will remain in a position to exert heightened influence in the election of the directors and officers of sanofi-aventis and in other corporate actions that require shareholders' approval. Continued ownership of a large percentage of the share capital and voting rights of sanofi-aventis by these two principal shareholders, affiliates of whom may also continue to be members of the sanofi-aventis board of directors, may have the effect of delaying, deferring or preventing a future change in the control of sanofi-aventis and may discourage future bids for sanofi-aventis other than with the support of these shareholders

Sales of our shares may cause the market price of our shares or ADSs to decline.

Neither Total nor L'Oréal are, to our knowledge, subject to any contractual restrictions on the sale of the shares each holds in our Company. Sales of a substantial number of our shares, or a perception that such sales may occur, could adversely affect the market price for our shares and ADSs.

vaccines are used in endemic settings to protect large populations in the developing world against severe infectious diseases, and are the basis for important partnerships with governments and organizations such as UNICEF. These vaccines are also used by militaries and travelers to endemic areas. As the global market leader in most of these vaccines, sanofi pasteur's Travel/Endemic franchise has provided stable, profitable growth. Additionally, sanofi pasteur has several lifecycle and new vaccine projects in development, including vaccines for Dengue Fever and Malaria, which are major burdens of disease-endemic areas in Asia, South America and Africa, and the leading causes of fever amongst travelers.

Research and Development

We have two Research and Development (R&D) organizations: one for our pharmaceutical activity (Scientific and Medical Affairs) and the other dedicated to our human vaccines activity, sanofi pasteur.

The objective of sanofi-aventis R&D organizations is to discover, develop, register and launch highly innovative compounds answering major unmet medical needs worldwide. They include a global force made up of over 17,600 people working in 28 research and development centers on three continents.

Pharmaceutical Research and Development

In 2005, the first full calendar year for sanofi-aventis, our large R&D organization was integrated and, on top of smooth progress for the projects in our portfolio, achieved significant goals with two major submissions in the United States and Europe (rimonabant and dronedarone), an important approval in the United States (zolpidem CR®), and approvals of several new indications for already-marketed products (*e.g.* Allegra®, Taxotere®, Eloxatine®, Ketek® and Lantus®). Furthermore, Plavix® was approved for marketing in Japan on January 23, 2006.

Global and Focused Organizations: Discovery and Development

Discovery Research

In 2005, Discovery Research continued its efforts to provide Development with a pipeline of high quality, innovative drugs that fulfill unmet medical needs or provide improved treatments for patients.

We benefit from the excellence of our scientists in six major therapeutic areas (Cardiovascular Diseases, Thrombosis & Angiogenesis, Metabolic Diseases, Central Nervous System Diseases, Oncology and Internal Medicine), with our activities currently targeting 12 out of the 16 diseases / conditions identified as demonstrating pharmaceutical gaps according to the World Health Organization.

In 2005, Discovery Research enriched the Development pipeline by entering 11 new molecules into Development:

- AVE8680, inhaled IKK-beta inhibitor, for the treatment of pulmonary inflammatory disorders (collaboration with Millennium),
- SSR106462 / CEP11981, a Tie2 / VEGFR-2 tyrosine kinase inhibitor, in oncology (collaboration with Cephalon),
- SAR102779, a NK2 antagonist, for the treatment of major depressive disorders and generalized anxiety disorders,
- SAR7226, a SGLT1/2 (sodium dependent glucose transporters) inhibitor, for the treatment of diabetes,
- SAR97276, a choline uptake inhibitor, for the treatment of malaria,
- SAR3419 (HuB4-DM4), a Tubulin inhibitor, DM4, coupled to anti-CD19 humanized monoclonal antibody, for the treatment of B cell lymphomas and leukemias (collaboration with Immunogen),
- SAR502250 (UDA-680), a Tau Phosphorylating Kinase I (GSK-3b) inhibitor, for the treatment of Alzheimer's disease and type 2 diabetes (collaboration with Mitsubishi),

- SAR21609, a toll-like receptor 9 agonist, for the treatment of asthma including virus induced asthma exacerbation (collaboration with Coley Pharmaceuticals),
- SAR501788, a peripheral benzodiazepine receptor ligand, for the treatment of sensory and motor neuron degeneration,
- SAR351034, a Peroxisome Proliferator – Activated Receptor (“PPAR”) agonist, for the treatment of dyslipidemia and type 2 diabetes in the context of metabolic syndrome, and
- SAR389644C, a DP antagonist, for the treatment of allergic rhinitis and asthma.

Furthermore, two new molecules entered development in early 2006:

- SAR 377142, an oral Xa inhibitor, for the prevention/treatment of thromboembolic diseases, and
- SAR 114646, an anti arrhythmic agent, for the treatment of atrial and ventricular arrhythmias.

Among the 11 compounds that entered development in 2005, we consider that five products are “first-in-class” (see Portfolio): AVE8680A, SAR7226, SAR97276, SAR3419A, and SAR502250.

Sanofi-aventis Discovery Research now combines the skills of around 3,000 people in a coherent global organization in which each scientist contributes positively his/her multidisciplinary and cultural approach to our drug discovery effort. Our aim is to continue to synergistically capitalize upon the unique skill-sets of our scientists so as to maintain the necessary high-quality research that will fulfill the expectations of our top management, shareholders and, above all, patients who are in need of new drugs.

Development

Sanofi-aventis’ development structure relies on a strong matrix organization that leads and coordinates the efforts and expertise of representatives from all functions, and at all stages of development, from the preclinical stage to marketing. The members of the Development team work together to register and deliver innovative new medicines to patients worldwide, while meeting critical strategic, technical and time-to-market requirements, in accordance with our high standards of quality and ethics.

One major principle of our matrix organization is the continuity of development from the very beginning of a molecule’s development (when it enters Development from Discovery) to the end of development (until the project is terminated or until the last potential approval is obtained). A project is defined by one molecule, even if multiple indications are possible. When a molecule enters development, a “project team” is formed with representatives from all relevant functions (including pharmacologists, clinicians, chemists, toxicologists, regulatory affairs specialists, marketing specialists and many others) who work together throughout the life of the molecule in development. Development ends when the last potential indication has been approved by Regulatory Authorities. Throughout development, our global organization aims at strategic and operational excellence, two key success factors.

In 2005, several hundred clinical trials were up and running in more than 60 countries for our projects under clinical development (including life cycle management projects), thanks to the consolidation and growth of our International Clinical Development organization. Most studies were managed through the in-house Clinical Research Units (CRU) network that consists of 26 units (covering, with their satellites about 40 countries), involving three of them created in 2005: Korea, China and Turkey. Korea was set up in January 2005 and particularly involved in thrombosis, cardiology, oncology and metabolism trials. The Turkish CRU was created early 2005 and is involved in three international clinical trials (ExTRACT, Origin and a study on Actonel®) including more than 900 patients in 32 centers. The Chinese CRU was created on June 1, 2005. Further to the mega-trial CCS2/COMMIT with Plavix® in acute myocardial infarction, Chinese clinical centers have been involved in two large international clinical trials: Extract (with Lovenox® in acute coronary syndromes) and Origin (with Lantus® in diabetes). The involvement of China will be considered for other studies in 2006, mainly in cardiology, diabetes, metabolic disorders, oncology and neurology.

As regards disclosure of clinical trial information, the research-based pharmaceutical industry with the participation of sanofi-aventis, committed in January 2005 to increasing the transparency of sponsored clinical

trials. Practitioners, patients and the community will benefit from broader distribution of clinical results. In addition, sanofi-aventis, in compliance with this policy, has taken the initiative of posting all clinical trials it, sponsors, other than exploratory trials, in a free, publicly accessible clinical trial registry, within three weeks of the initiation of patient enrolment (unless there are alternative national requirements).

Portfolio

The research and development process historically takes from 10 to 15 years from discovery to initial product launch and is conducted in various stages. During the “pre-clinical” stage, research scientists perform pharmacology and toxicology studies on various animals. Before testing on humans, an application for the compound must be filed with and approved by the requisite regulatory authorities. Testing on humans is performed in different clinical phases to demonstrate the safety and efficacy of a new compound:

- *Phase I.* In clinical phase I, studies are performed on healthy human volunteers to obtain information concerning safety, preliminary dose-ranging, pharmacokinetics and preliminary interaction with other medications.
- *Phase IIa.* In clinical phase IIa, studies are performed to research the pharmacological activity of the dose range determined in the phase I studies and/or to assess preliminary therapeutic activity in patients.
- *Phase IIb.* In clinical phase IIb, the aim is to determine the risk/benefit ratio, *i.e.*, to demonstrate the clinical activity and to determine the optimal dose in a larger and more varied population.
- *Phase III.* In clinical phase III, we verify the clinical efficacy of the compound on a large population of patients (usually between 3,000 and 5,000 volunteers). These studies involve control groups taking a reference compound or a placebo (an inactive compound identical in appearance to the study compound).

Together, phases IIb and III typically take from three to five years to complete. Thereafter, an application containing all data for the proposed drug is sent to regulatory authorities for approval, which may take an additional six months to two years or longer. There are two types of further clinical trials: one called phase IIIb, where new indications are sought; and one called phase IV trials, which are generally carried out after product launch to continue to monitor the efficacy and safety of a new drug.

A Rich, Innovative and Balanced R&D Portfolio

The table below shows the composition of our R&D portfolio at the end of 2005:

	Preclinical	Phase I	Phase IIa	Phase IIb	Phase III	Launched / LCM
Cardio-vascular	AVE0657	HMR1069	AVE0118	XRP0038	Multaq® **	Tritace®
	AVE3085	AVE1231	ataciguat	SSR149744		Aprovel®
	AVE4454	AVE9488		AVE7688		
	AVE4890			SL650472		
	SAR114646					
Thrombosis	AVE6324	AVE3247	AVE5026	otamixaban	idraparinux	Lovenox®
	SSR128428			SR123781		Plavix®
	SSR128429			SSR126517		
	SAR 377142					
Metabolic disorders	AVE0897	AVE5376	AVE1625*	SR147778*	rimonabant**	Amaryl®
	SAR7226	SSR162369	AVE0847	AVE0010		Lantus®
	SAR351034	AVE5530	AVE2268			Apidra®
	AVE9423	AVE8134				
Oncology	SSR106462/CEP11981	AVE8062	XRP6258	SR31747	XRP9881 tirapazamine xaliproden* alvocidib	Eloxatine®
	SAR3419	AVE9633	Uvidem®			Fasturtec®
	AVE1642	SSR125329	AVE0005			Taxotere®
	SSR 97225	CEP7055				
	SSR 128129					
	SSR244738					
Central Nervous System	SSR 250411					
	SAR102779	AVE9897*	HP184	M100907	teriflunomide SR58611 xaliproden* saredutant eplivanserine rimonabant** SSR591813	Rilutek®
	SAR501788	SSR125543	AVE1625*	SR57667		Depakine®
	SAR502250	SSR411298	SSR149415			Stilnox®
	AVE8112	SSR504734				Ambien CR™
	AVE8488	SSR180575				
	SSR101010	SR147778*				
	SSR103800					
	SSR126374					
	SSR180711					
	SSR241586					
Internal Medicine	SAR389644	XRP2868	icatibant	SR140333	Alvesco®** SR121463	Arava®
	SAR21609	AVE9897*	SSR240600	ciclesonide/		Allegra®
	SAR97276	ferroquine	pleconaril	formoterol		Ketek®
	AVE8680	SSR126768	SSR240612			Actonel®
	AVE0675	SSR150106				Xatral®
	AVE8923	AVE1701				Flisint® (fumagillin)

* Compounds appearing in more than one therapeutic area

** NDAs have been submitted for these products

Sanofi-aventis Pharmaceutical Scientific and Medical Affairs are currently developing 106 compounds, in six therapeutic areas (these figures do not include the vaccines portfolio; for details of this portfolio, please refer to "Vaccines Research and Development" below). We believe this is one of the strongest and most promising R&D portfolios in the pharmaceutical industry, particularly strong in the CNS and oncology therapeutic areas, where the needs for better drugs to treat neurodegenerative diseases, dementia and psychosis are still considerable. The portfolio is well balanced throughout all our therapeutic areas. With 60 compounds in early development (preclinical and phase I), and 46 in late development (phase II and III), our pharmaceutical portfolio is also well balanced in terms of phase distribution, with a quite significant reservoir of compounds in the early phases.

The sanofi-aventis R&D portfolio is particularly innovative, as indicated by the number of “first-in-class” new molecular (or biological) entities in this portfolio. A molecule is considered as “first-in-class” if, at the time of its entry into development, to our knowledge, no other active substance with the same mode of action is under active preclinical or clinical development or already on the market. By the end of 2005, 42 products (small molecules) are first-in-class in our portfolio.

Sanofi-aventis Scientific and Medical Affairs Achievements in 2005

The strength of the sanofi-aventis’ portfolio is illustrated through the key achievements and project highlights of our R&D in 2005.

In 2005, 11 new compounds have entered preclinical development (see Discovery Research). Also, another compound re-entered the oncology development portfolio, alvocidib (HMR1275), a cyclin-dependent kinase inhibitor, for which phase III studies in chronic lymphocytic leukaemia will be initiated.

In 2005, 12 compounds entered phase I, while four phase II programs have started and nine phase III/IIIb programs have been initiated.

In terms of regulatory submissions, two major NDAs were submitted in April 2005 in the United States and Europe for rimonabant (obesity, metabolic disorders and smoking cessation), and in June 2005 for dronedarone (atrial fibrillation). Furthermore, the mutual recognition process for Zolpidem MR was initiated in Europe in 2005.

Several sNDAs were submitted in 2005 in the United States and in Europe for major products like Actonel®, Allegra®, Aprovel®, Taxotere® (gastric cancer, granted priority review in the United States), or Plavix® (acute myocardial infarction). In Japan, the amiodarone IV (Ancarone®) dossier was submitted, as well as a new formulation for Lantus®.

As far as regulatory approvals are concerned, Ambien CR™ was approved and launched in the United States in 2005. One marketing authorization was obtained in France for an orphan drug, Flisint® (fumagillin), a very potent treatment for a very rare disease (microsporidiosis in severely immuno-compromised patients).

Several sNDAs were granted in the United States, Europe or Japan to major products including Taxotere®, Eloxatine®, Allegra® or Lantus®: details are given below under “– Project Highlights.”

Furthermore, in Japan, the approval of Plavix® was obtained on January 23, 2006.

Project Highlights

Life cycle management development programs for our marketed products are described above under “Major Products.”

Cardiovascular

Certain of our principal compounds in the fields of cardiovascular medicine currently in phase IIIb, phase III or phase IIb clinical trials are described below.

- **Multaq®** (Dronedarone SR33589, atrial fibrillation; phase III). Amiodarone, which we have marketed since the late 1960s under the brand name Cordarone®, is a current reference anti-arrhythmic. With dronedarone, a potential successor to Cordarone®, our goal is to develop a new treatment with the efficacy of amiodarone, but with an improved safety/tolerability profile. The first indication being developed for dronedarone is the prevention of recurrences of atrial fibrillation, the most common cardiac rhythm disorder. The usual treatment for acute atrial fibrillation is an external electric shock to the heart, which is then generally followed by an anti-arrhythmic pharmacotherapy to avoid recurrences, which are extremely common. The EURIDIS (Europe) and ADONIS (North and South America, Australia and South Africa) phase III trials, involving 1,245 patients with atrial fibrillation have confirmed the good efficacy and safety of dronedarone as an anti-arrhythmic drug, particularly with the absence of any pro-arrhythmic effect. Based on these data, a registration file has been submitted in Europe and in the United States and is currently under review by Health Authorities.

- **SSR149744C** (atrial fibrillation; phase IIb). Besides the improved tolerability as compared to amiodarone, SSR149744C has a different metabolic profile from amiodarone and is therefore expected to be devoid of the drug interactions commonly described with amiodarone. The targeted indication for SSR149744C is atrial fibrillation. SSR149744C is in phase IIb since December 2004.
- **NV1FGF** (XRP0038, non-viral fibroblast growth factor 1, phase IIb) is an injectable non-viral DNA plasmid and gene therapy-based approach for the promotion of angiogenesis in peripheral arterial disease (PAD). Following encouraging results in phase IIb with statistically significant prolongation of the time to amputation in patients with critical limb ischemia, XRP0038 development will continue in this indication in phase III in 2006.

Thrombosis

There are four compounds that are currently in later-stage development in thrombosis:

- **Idraparin sodium** (SR34006, thromboembolic events; phase III). Idraparin sodium is a selective indirect inhibitor of coagulation factor Xa with a long duration of action. It is a synthetic pentasaccharide. The VAN GOGH phase III program is investigating the efficacy and safety of idraparin sodium in the long-term treatment of thromboembolic events in patients suffering from deep-vein thrombosis or pulmonary embolism and is progressing as planned. In the AMADEUS program studying idraparin sodium in comparison to Vitamin K antagonists in the prevention of thromboembolic events associated with atrial fibrillation, a substantially lower incidence of events than initially expected was observed. As a result, sanofi-aventis has decided in agreement with the Steering Committee and the DSMB to make no further recruitments in the AMADEUS program. The principal reason was the very large number of patients that would be required in order to show statistical significance.
- **SSR126517** (thromboembolic events, phase III to start second quarter of 2006). SSR126517 is a neutralizable selective inhibitor of coagulation Factor Xa. It has the same pentasaccharidic structure as idraparin sodium, with the addition of a biotin "hook" to allow quick and efficient "fishing" by its specific neutralizing agent, avidin. It demonstrated similar anticoagulant, pharmacokinetics and antithrombotic properties to idraparin sodium. Based on this similarity to idraparin sodium we plan to start a bridging clinical development including phase III program in patients with pulmonary embolism and deep vein thrombosis in the second quarter of 2006.
- **SR123781** (Acute coronary syndrome; phase IIb). SR123781A is a synthetic hexadecasaccharide. It includes two functional domains, an antithrombin binding domain, and a thrombin binding domain, responsible for its dual anticoagulant activity via indirect inhibition of coagulation factors Xa and IIa. Based on its demonstrated potent antithrombotic activity in animal models, it is currently being studied in phase IIb in patients with acute coronary syndromes treated with an invasive strategy.
- **Otamixaban** (XRP0673, Acute coronary syndrome; phase IIb). Otamixaban is an injectable non-saccharidic synthetic direct inhibitor of coagulation factor Xa. It exhibits a fast on- and offset of action. It is being investigated in patients undergoing cardiac catheterization.

Metabolic Disorders

Our main compounds currently in late-stage development for metabolic disorders are described below.

- **Acomplia®** (Rimonabant, SR141716), metabolic syndrome and weight management, smoking cessation; phase III). Rimonabant is the first in a new class of therapeutics called selective CB-1 receptor blockers. CB-1 receptors were found first in the brain and have recently also been identified in several other human tissues, including adipocytes. They are part of the endocannabinoid system, which is critically involved in the regulation of body mass and body weight, lipid metabolism and insulin resistance. The endocannabinoid system is also involved in the sensitivity to positive re-inforcers such as nicotine.

Rimonabant has completed a phase III program in obesity, cardiometabolic risk management and related disorders like type 2 diabetes and dyslipidemia (the RIO program: rimonabant in obesity) as well as a program in smoking cessation (STRATUS program). In 2005, registration dossiers were submitted in the United States and Europe. On February 17, 2006, an "approvable" letter for the

weight management indication and a “non-approvable” letter for the smoking cessation indication were received from the FDA. Sanofi-aventis continues to work closely with the FDA on this matter.

- **AVE0010** (Type 2 diabetes mellitus), our injectable GLP-1 agonist, entered Phase IIb in patients with Type 2 diabetes mellitus. Compounds that lead to increased circulating levels of GLP-1 have the potential not only to lower blood glucose but also rejuvenate the insulin-producing beta cell. AVE0010 was licensed in from Zealand Pharma.

Oncology

The sanofi-aventis oncology portfolio represents a broad spectrum of novel agents with a variety of mechanisms of action for treating cancer and/or cancer side-effects, including cytotoxic agents, anti-mitotic agents, bioreductive agents, receptor antagonists, anti-angiogenic agents, anti-vascular agents, monoclonal antibodies, and cancer vaccines, as well as supportive care therapies. Our principal compounds in the field of oncology currently in clinical trials are described below.

- **Tirapazamine** (SR259075, head and neck cancer; phase III). Tirapazamine is an anti-cancer agent activated under hypoxic conditions to promote the destruction of resistant hypoxic cells. This innovative mechanism of action is hypothesized to decrease the rate of relapse in tumors associated with hypoxia (*i.e.* head and neck cancer). Phase III trials on tirapazamine in combination with cisplatin and radiation in head and neck cancer are ongoing. Exploratory studies in other tumors associated with hypoxia are also ongoing.
- **Xaliproden** (chemotherapy induced neuropathy; phase III). Xaliproden is an orally active neurotrophic agent which is currently being studied in phase III trials for the treatment of chemotherapy-induced neuropathy.
- **XRP9881** (metastatic breast cancer failing taxane therapy; phase III). XRP9881 is a new taxane derivative that has been designed to overcome resistance to existing taxanes, docetaxel and paclitaxel. In phase II, XRP9881 has proved to be active on metastatic breast tumors progressing after taxane therapy. XRP9881 has also been shown to cross the blood-brain barrier, and therefore could potentially be active on brain metastasis.
- **Alvocidib** (HMR1275, chronic leukocytic leukaemia; Phase III). Alvocidib is a novel cyclin-dependent kinase inhibitor. Development was terminated by Aventis in 2004 due to lack of clinical efficacy of the tested regimen. Results from a Phase I/II study in patients with refractory chronic leukocytic leukaemia conducted at Ohio State University under an agreement with the U.S. National Cancer Institute demonstrated a 43% partial response rate with overall survival after 12 months when alvocidib was administered using a novel dosing regimen of a 30 minute bolus followed by 4-hour infusion. Based on these results, development was re-initiated using the bolus/infusional regimen in hematological malignancies.

Central Nervous System

Certain of our principal compounds in the Central Nervous System field currently in phase II or III clinical trials are described below.

- **SR58611** (depression; phase III). SR58611 is a beta-3 adrenergic receptor agonist. This substance stimulates neuronal activity in a specific region of the prefrontal cortex and could give rise to a new class of anti-depressants. In a phase II trial in patients suffering from severe depression with melancholic features, SR 58611 was observed to be superior to fluoxetine, a reference treatment, and was well tolerated. A Phase III program in depression is ongoing, moreover a phase III clinical program in General Anxiety Disorder started in 2005.
- **Saredutant** (SR48968, depression; phase III). Saredutant is an NK2 receptor antagonist developed for the treatment of Major Depressive Disorders. The patient inclusion of the two first phase III clinical trials have been completed.
- **Teriflunomide** (HMR1726, multiple sclerosis; phase III). Teriflunomide is a dihydroorotate dehydrogenase inhibitor. An international phase III development program is ongoing.

Exhibit L



sanofi aventis

Because health matters

**THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION PUBLISHES
THE RIO-NORTH AMERICA STUDY**

***Study Shows Rimonabant Maintains Improvements in
Multiple Cardiometabolic Risk Factors For Up to Two Years***

Paris, France, February 14, 2006 – Sanofi-aventis announced that the results of the RIO North America trial were published today in The Journal of the American Medical Association (JAMA). The trial evaluated two-year treatment with rimonabant in overweight or obese patients, many of whom were at increased risk for diabetes and heart disease through the presence of additional risk factors including increased waist circumference (abdominal obesity), elevated blood pressure or abnormal lipid levels. The findings showed that patients treated with rimonabant 20 mg once daily experienced significant reduction of their waist circumference and body weight as well as improvements in multiple cardiometabolic risk factors, including HDL (good) cholesterol, triglycerides and an estimate of insulin sensitivity.

“The RIO-North America trial results indicate that rimonabant 20 mg once daily produced sustained clinically meaningful weight loss and improvements in associated risk factors during two years of treatment,” said Xavier Pi-Sunyer, M.D., Chief of the Division of Endocrinology, Saint Luke’s – Roosevelt Hospital Center, Columbia University, New York, Professor of Medicine at Columbia University College of Physicians and Surgeons; and Principal Investigator of the RIO-North America trial. *“The sustained improvements we see in several risk factors were beyond what was expected from the observed weight loss and suggests that rimonabant represents an exciting breakthrough in our quest to improve the multiple cardiometabolic risk factors contributing to increased risk for diabetes and heart disease in patients who have abdominal obesity.”*

At one year, the weight loss and reduction in waist circumference for all patients treated with rimonabant 20 mg once daily enrolled in the RIO-North America trial were significantly greater than placebo. Patients treated with rimonabant 20 mg once daily for two years once daily achieved an average 3.6 kg (7.9lbs.) greater weight loss than those in the placebo group ($p<0.001$). In contrast, those patients switched to placebo for the second year of treatment regained the majority of the weight they had lost the previous year. Consistent with the weight loss achieved, patients treated with rimonabant 20 mg once daily experienced an average reduction in waist circumference of 2.8 cm (2.1 inches) more than those in the placebo group ($p<0.001$). High waist circumference is a practical indicator of intra-abdominal adiposity (excess fat in the abdomen), which is acknowledged as a risk factor for cardiovascular disease and type 2 diabetes.¹

Rimonabant-treated patients achieved significant improvements in multiple cardiometabolic risk factors that often form a high-risk cluster in overweight or obese patients with an increased waist circumference. In patients treated with rimonabant 20 mg once daily for two years, HDL (good) cholesterol increased by 6.3 % more than those in the placebo group ($p<0.001$) and triglycerides were reduced by 8.5 % more than those in the placebo group ($p<0.001$). Although patients with diabetes were not included in the study,

press release



press release

patients in the ITT population on rimonabant 20 mg once daily had significantly improved HOMA estimated insulin sensitivity at both one and two years compared to those on rimonabant 5 mg once daily and those on placebo ($p < 0.01$). A statistical analysis suggested that the effect of rimonabant on HDL-cholesterol, triglycerides, fasting insulin and insulin sensitivity were approximately twice what could be expected from the weight-loss achieved.

Consistent with the findings of other RIO trials, the percentage of patients who received treatment with rimonabant 20 mg once daily for two years and who achieved a greater than 5 % reduction in overall body weight was 40 % compared with 19 % in those patients receiving placebo ($p < 0.001$). The percentage of patients achieving a greater than 10 % reduction in body weight was also greater with rimonabant 20 mg compared to placebo (17 % vs. 8 %; $p < 0.001$). The percentage of patients achieving a 5% or greater weight loss at one year was 48.6 % for patients receiving 20 mg of rimonabant ($p < 0.001$) and 20 % for patients receiving placebo. The percentage of patients achieving a 10% or greater weight loss at one year was 25.2% for patients receiving 20 mg of rimonabant ($p < 0.001$) and 8.5% for patients receiving placebo. The 5 mg dose did not show statistical significance for all comparative criteria versus placebo.

Importantly, the RIO-North America trial results suggest that patients taking rimonabant 20 mg once daily maintained their weight loss during the second year of treatment and continued to experience favourable improvements across multiple cardiometabolic risk factors.

"These findings highlight that sustained weight loss and associated improvements in multiple cardiometabolic risk factors require long-term treatment," said Louis Aronne, M.D., Director of the Comprehensive Weight Control Program at NewYork-Presbyterian Hospital/Weill Cornell Medical Center, Associate Professor of Medicine at Weill Medical College of Cornell University, President of the North American Association for the Study of Obesity (NAASO), and investigator in the RIO-North America trial. *"As with any chronic disorder, such as diabetes, high cholesterol or hypertension, treatment is often effective when patients remain on therapy long-term."*

Safety and tolerability were consistent with other reported RIO studies. In the first year, rimonabant 20 mg once daily was generally well-tolerated and adverse events were mostly mild to moderate. The most common side effects for the placebo and rimonabant 20 mg arms included upper respiratory tract infection (15.2 % vs. 18.5 %), nasopharyngitis (14.0 % vs. 17.0 %), nausea (5.8 % vs. 11.2 %), influenza (7.7 % vs. 8.8 %), anxiety (2.1 % vs. 6.1 %), and depressed mood (3.1 % vs. 5.2 %). Overall, discontinuation rates due to adverse events in the first year of the trial were 7.2 % in placebo treated patients vs. 12.8 % for rimonabant 20 mg patients. The most common adverse events leading to discontinuation for the placebo and rimonabant 20 mg patients respectively were depressed mood disorder (1.3 % vs. 2.2 %), anxiety (0.3 % vs. 1.0 % and nausea (0.2 % vs. 0.9 %).

In the second year, overall rates of adverse events, discontinuations and adverse event-related discontinuations were lower than in the first year, with no significant differences between rimonabant 20 mg and placebo.

The RIO-North America trial publication concluded that, rimonabant, the first CB1 blocker, produced sustained, clinically meaningful weight loss and favourable changes in cardiometabolic risk factors including HDL-C, triglycerides, and HOMA estimated insulin sensitivity.



ress release

About the RIO-North America Trial

RIO-North America was a two-year, phase III, multinational, multicentre, randomised, double-blind, placebo-controlled, parallel-group, fixed-dose study of 3,045 patients treated with rimonabant 20 mg, rimonabant 5 mg or placebo. Study centers were located in Canada and the USA.

Study participants were male and female 18 years of age or older with a Body Mass Index (BMI) greater than 30 kg/m² or 27 kg/m². The study did not include diabetic patients, but many of the patients had elevated blood pressure and/or abnormal lipid levels, and of these a proportion were receiving treatment for their risk factors. After a screening period of one week, all patients entered a four-week single-blind placebo run-in period after which patients were randomly allocated to one of the three treatment groups: placebo or rimonabant 5 mg or 20 mg for 52 weeks of double-blind treatment using a randomisation ratio of 1:2:2. After the first year of treatment, patients who received rimonabant 5 mg or 20 mg were re-randomised to either the same dose of rimonabant or placebo using a randomisation ratio of 1:1 for an additional one year treatment period (the placebo group remained on placebo during the second year). During the two-year trial period patients were asked to reduce their diet by 600 kcal/day and increase their level of physical activity.

RIO-North America is one of four phase III trials - RIO-Diabetes, RIO-Lipids, RIO-Europe and RIO-North America - examining the effects of rimonabant on cardiometabolic risk factors in 6,600 overweight or obese patients with or without comorbidities for up to two years. In these studies, rimonabant has demonstrated a wide array of cardiometabolic improvements in blood sugar levels (HbA1c), blood lipid levels (HDL-cholesterol and triglycerides), blood pressure, weight and waist circumference as well as improvements in such emerging cardiometabolic risk factors as adiponectin and C-reactive protein (CRP) which are markers of inflammation associated with cardiovascular risk.^{2, 3} The improvements seen in HbA1c, HDL-cholesterol, triglycerides, adiponectin and CRP were beyond what could be explained by weight loss alone, suggesting a possible direct effect of rimonabant on cardiometabolic risk factors.

The results of the RIO-North America trial were first released at the American Heart Association congress in New Orleans in November 2004.

About rimonabant

Rimonabant is the first selective CB1 receptor blocker currently under review by the U.S Food and Drug Administration (FDA) and European Medicines Agency (EMA). Rimonabant, discovered by researchers at sanofi-aventis, works by selectively blocking CB₁ receptors found centrally in the brain, as well as in peripheral tissues, including fat cells, the liver and muscle. Rimonabant works to regulate the activity of the endocannabinoid system (EC system). The EC system is a newly discovered physiological system believed to play an important role in regulating body weight, controlling energy balance, as well as glucose and lipid (or fat) metabolism. The EC system is potentially overactivated in overweight and obese patients.

About Cardiometabolic Risk

Cardiometabolic risk (CMR) consists of modifiable risk factors that may predispose people to type 2 diabetes and heart disease. Many of these factors present clinically in specific clusters. CMR factors



include: intra-abdominal adiposity (abdominal fat), low HDL levels, elevated triglycerides, insulin resistance and elevated blood glucose (high blood sugar), elevated blood pressure (hypertension), smoking, and elevated LDL levels (bad cholesterol). CMR factors also comprise emerging risk markers such as adiponectin, a protein associated with reduced risk of diabetes and heart disease, and CRP, a marker of inflammation associated with cardiovascular risk.

About sanofi-aventis

Sanofi-aventis is the world's third largest pharmaceutical company, ranking number one in Europe. Backed by a world-class R&D organisation, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine, and vaccines. Sanofi-aventis is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward-Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expect," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2004. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

Media contact:

Nazira Amra +33 (0) 630 32 63 15

Julissa Viana +1-516-578-0461

References:

¹ Sharma A. M. Adipose tissue a mediator of cardiovascular risk. Int J Obes Relat Metab Disord. 2002, 26 Suppl 4: S5-S7

² Van Gaal L F, Rissanen A.M, Sheen A.J, Ziegler O., Rossner S, for the RIO-Europe study group. Effects of the cannabinoid-1 receptor blocker rimonabant on weight reduction and cardiovascular risk factors in overweight patients: 1-year experience from the RIO-Europe study. Lancet 2005; 365:1389-97

³ Despres J-P., Golay A, Sjostrom L., for the RIO-Europe study group. Effects of rimonabant on metabolic risk factors in overweight patients with dyslipidemia. New Engl J Med 2005, 353:2121-34.

Exhibit M



**Sanofi-aventis received from the FDA
an approvable letter for rimonabant for weight management
and a non approvable letter for smoking cessation**

Paris, France, February 17, 2006 - Sanofi-aventis announced today that it has received from the U.S. Food and Drug Administration (FDA), *Division of Metabolism and Endocrinology Products* an approvable letter for rimonabant for weight management, and from the *Division of Anesthesia, Analgesia and Rheumatology Products* a non approvable letter for smoking cessation.

Sanofi-aventis will continue to work in close collaboration with the FDA.

Rimonabant is the first in a new class of therapeutic agents called CB₁ blockers.

About sanofi-aventis

The sanofi-aventis Group is the world's third largest pharmaceutical company, ranking number one in Europe. Backed by a world-class R&D organization, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine, and vaccines. The sanofi-aventis Group is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward-Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expect," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2004. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

press release

Exhibit N

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Event Date/Time: Feb. 24. 2006 / 9:00AM ET

FINAL TRANSCRIPT

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

CORPORATE PARTICIPANTS

Jean-Francois Dehecq

Sanofi-Aventis - Chairman and CEO

Sanjay Gupta

Sanofi-Aventis - IR

Jean-Claude Leroy

Sanofi-Aventis - SVP and CFO

Hanspeter Spek

Sanofi-Aventis - EVP Pharmaceuticals Operations

Wayne Pisano

Sanofi-Aventis - SVP Sanofi Pasteur, Commercial Operations

Pierre Chancel

Sanofi-Aventis - SVP Global Marketing, Pharmaceuticals

Gerard Le Fur

Sanofi-Aventis - SVP, Science and Medical Affairs

Michel DeWilde

Sanofi-Aventis - SVP Sanofi Pasteur, Research and Development

CONFERENCE CALL PARTICIPANTS

Tim Anderson

Prudential Securities - Analyst

Andy Kocen

Redburn Partners - Analyst

Jo Walton

Lehman Brothers - Analyst

Graham Parry

Merrill Lynch - Analyst

Ahmed Roy

Citigroup - Analyst

Michael Leacock

ABN Amro - Analyst

John Murphy

Goldman Sachs - Analyst

Alex Evans

Deutsche Bank - Analyst

Andrew Oh

Leerink Swann & Company - Analyst

Alexandra Hauber

Bear Stearns - Analyst

Shaun Ballane

Wall Street Journal - Analyst

PRESENTATION

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Operator

Good day, ladies and gentlemen, and welcome to today's full year results 2005 conference call. For your information, this conference is being recorded. The 2005 full year results are reviewed by Sanofi-Aventis management. At this time, I would like to turn the call over to your host today, Mr. Dehecq. Please go ahead, sir.

Jean-Francois Dehecq - *Sanofi-Aventis - Chairman and CEO*

Okay. Thank you to be with us, and good afternoon, or good evening. I suppose that you start, Sanjay.

Sanjay Gupta - *Sanofi-Aventis - IR*

Yes. Good afternoon, everybody. This is Sanjay from the Investor Relations team. I would just like to begin the meeting by the customary reading of the formal forward-looking statement.

The presentation that we make here today contains forward-looking statements as defined by the Private Securities Litigation. These forward-looking statements are not statements of historical facts. The actual results of the Company are subject to various risks and uncertainties, and these results -- the real results could differ materially from those expressed in today's presentation.

I invite you to please read the forward-looking statement in its entirety, and I give it back to Mr. Dehecq. Thank you.

Jean-Francois Dehecq - *Sanofi-Aventis - Chairman and CEO*

Thanks. First of all, I give the floor to Jean-Claude Leroy for the finance.

Jean-Claude Leroy - *Sanofi-Aventis - SVP and CFO*

Thank you, Jean-Francois. I will comment on the fourth quarter of 2005 and the full year of 2005, and I invite you to keep the global P&L on your left side so we can comment at the same time on the various slides for the more detail on the P&L. So I will begin directly on slide number five.

As far as sales are concerned, going directly to the reported basic growth of 7% on the fourth quarter, which translates in 8.4% for the entire year of 2005, we had the favorable impact of the U.S. dollar against euro in -- as all of you know, I'm sure, during that fourth quarter.

Then, going directly to the gross margin level, if I can switch the slide - yes. Thank you, gross margin ratio. What happened during 2005, 1.2 percentage point improvement during that year for the reason we already developed together during the year, favorable product mix, purchasing efficiency and strong sales. But as you can see, during the fourth quarter, and I'm sure all of you know, we had that [generification] of the main euro group, Allegra, and those three other products in the United States. So that the gross margin was lower in its improvement during that quarter, 0.9%, due to that impact of the generic product.

Or the other way round, during the fourth quarter we had a favorable impact on the royalty side -- the royalty received from BMS and Plavix and Avapro. You know the rate of growth of the product in the States and to that you have to add up the favorable impact of the U.S. dollar versus the euro.

R&D expense. You see that there has been an improvement during the fourth quarter, plus 6.6%. We were around zero at the end of the third quarter, so that does translate into 2% on the full year. This is the beginning of the reinforcement of the R&D

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

forces, to monitor the clinical trials -- the heavy program that Gerard will tell upon a little bit later. So that we finally see something moving up in the R&D expense during that 2005 year.

For the rest, the main concern or the main topic of the full year was the discontinuation of some of our R&D collaborations, so I am talking a little bit about synergies and I will be back on this subject a little bit later on in my presentation.

Selling and general expenses. There is an important increase to be seen in the fourth quarter, plus 12%, which translates in 4.6% in 2005. We've said that -- during the year that there was a huge discrepancy between the commercial expenses and the G&A expenses. This is even more true in the fourth quarter.

We've put a lot of expenses behind the switch of Ambien to Ambien CR. We've put money in order to prepare for the launch of Plavix in Japan and you know we've got the authorization to market during the month of January and obviously we are also prepared for the launch of Rimonabant. So that, in addition to the support to the existing products, we spent a little bit more money on these three products and that's the reason for which we've had a rather important increase in these selling expenses.

To the contrary, the G&A went on decreasing during the fourth quarter. On the full-year basis now, on that 4.6% again selling were more, and I would say much more, than sales rate. To the contrary, to the opposite, the G&A was very much decreasing. I can say that it was even a little bit more than 10% decrease during the full year.

Next, I won't spend too much time on these technical details, even though they are very important, just because I am going to feed back a little bit later on on these specific items, which were -- on which we're used to discuss -- to see the impact on the global P&L. Let's just say that we've given -- I've given the reason for which we've seen an increase by only 4% of the operating income current during the fourth quarter, the generification from one side, and these efforts in order to prepare for the launch of 2006 and also for the switch of Ambien. I don't mention the impact of employee shares on the global year. We've been talking of a 19% improvement of that level of the P&L.

Then, again, when we go from operating income current to operating income, we have litigation solution with Bayer during the fourth quarter. That doesn't solve all the problems, but a lot of them. And that does translate with a favorable impact of close to 60m during that fourth quarter, which is a positive to the P&L, which is to be noticed again. We'll come back to that in the operating -- the specific item level.

Another bunch of specific items, you'll remember about the restructuring cost pre-acquisition programs. We are now over as of the end of 2005. You'll remember -- I'm sure you remember that the specific [indiscernible] last year on the [indiscernible] different scope this year. We already discussed that. Oral care business disposal on which we made a gain of around 70m plus, at this level.

So after that level, we come to the financial expenses. A huge drop on this line item. More than 100m in the fourth quarter, which translates into 500m decrease during the year. Out of which the financial expenses of the debt was 50m positive in comparison during the fourth quarter, when it was \$200m during the full year.

In addition to that, a certain number of gains on disposal of some biotech companies. As you can see here, lower provision for financial investment. Which all in all adds up to a market -- a gain on the mark to market on financial instruments, which do translate. Add to that 500m difference between the 245m as compared to the 739m in 2004.

Just a word on the effective tax rate. You remember that last year we said, when presenting the 2004 financials, that the fourth quarter levels were a little bit unusual, but you had better look at the entire year rate, which was 30.9%. You can see that this year we had a 31.3% effective tax rate, so I'll just say a few words that it's totally comparable between one year and the other.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

There's nothing special to mention on the share of profit and loss from associate and minority interests, apart that it does translate very much what happens in our alliance with BMS and Plavix and Avapro. The only thing there is to mention is that there was substantial growth from Merial, which is our JV in animal health with Merck, and this is true in quarter four and this is true for the entire year.

Then we come to the bottom line of the P&L. Plus 20% at the EPS level on the fourth quarter, plus 25.7% for the entire year at 4.74 a share. This is over a 3% increase in the ratio of net income to sales, and you can see that reaching 23.2% at the end of 2005, does compare rather favorably at -- in -- within our competitors.

What we're used to give a look at is these selected items I was mentioning before. You see the restructuring and pre-acquisition programs, I have nothing to add up because this is something which is very well known. The gain and loss on divestment, I mentioned the oral care business, and mentioned about the companies for this year. All in all we're close to 200m before tax. The litigation with Bayer I already mentioned.

We come directly to the conclusion, and I can give you the figures after tax, these ones are before tax. We're talking of 7m positive fourth quarter of 2004, which is to [become that] 84m in the fourth quarter of 2005. An improvement therefore of 77m. So it's easy to say that when we give a closer look to the performance of the third -- fourth quarter of 2005, we're talking of performance which is closer to a plus 15% at the EPS level than the 20% we saw on the previous chart, the general chart of the P&L.

If I looked at, as I already mentioned, the effective tax rate during the fourth quarter was not representative in '04, a better year, so there is an advantage in the comparison. Let me tell you that the underlying growth in the quarter -- fourth quarter of '05 as compared to the same quarter in '04 was rather around 10% at the EPS level.

Back on the full year, the figures, global figures translate to minus 5m for the entire 2004, when it comes up to 168m after tax in 2005. Again, making the comparison between '04 and '05 without these selected items, it's fair to say that the 26.1% of increase in the net result translates into 22 -- plus 22.6%, and that does also translate around plus 22% at the EPS level.

A word about where we are on the synergy and restructuring cost level. We said earlier in the year that we would do on a cumulative basis over 75% at the end of this year. As you can see on this chart, precisely 87% reached, so let's say that we're close to 90%. 1.4b out of the 1.6b we mentioned when we [last year] operation with Aventis. So we've been quicker than we figured out that we would be, and that therefore there are only a few remaining amounts to be put in addition to the P&L next year. But the great majority of the synergies are already there.

As far as the restructuring costs are concerned, we figured out we would reach a cumulative 2b before tax. As you can see, we reached 1.6b by the end of last year, which means that we should be under -- largely under the 2b target which we mentioned in 2004.

Going through the cash flow information, all what I have said translates in a very important improvement in 2005. As you can see on this chart, the free cash flow generated during 2005 reached 4.3b. It's worth mentioning that the securitized receivables which existed up to the end of 2004 did not exist any more at the end of 2004 -- 2005. That does mean that we did refinance the selling of receivables for close to 500m. So it's fair to say that during 2005 we had free cash flow of around 4.8b, which can be compared to the 4.1b and even more to 2.7b, because in 2004 we had a set disposal of 1.4b, and as you can see in 2005, a set disposal and acquisition equal balance to zero. So the gearing is very favorable at the end of 2005 - 21.2%.

I will not comment, probably, on the balance sheet. Only to say that there is a very important favorable currency effect, mainly dollar, because all in all, on the full balance sheet, it does amount to 6b. I won't give any more detail, I guess that you've caught up all the details. As through the previous presentation, I am ready and happy to answer any questions on this one.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

The Board of Directors yesterday decided to propose to the AGM to give 1.52 per share dividend out of this result, which is close to 27% increase over last year. And it's fair to remember that if we look a little bit behind, it will have been 130% dividend growth over the last five years.

Then a word, to finish up, on the guidance for 2006. We said plus 10% on the adjusted EPS level. Obviously, this is despite the full impact of generics in the United States, mainly of Allegra. This is also taking into account the substantial launch costs of Plavix in Japan and Rimonabant, and should add up the continuation of the conversion, or the switch, from Ambien to Ambien CR. And this is also assuming 300m after tax of selected items, the one we described earlier, as compared to this 168m I described for the full year 2005.

This 300m I was referring to is the theoretical amount of the capital gain on disposal of Exubera. The exact amount will be known a little bit later on during the quarter number one when the closing occurs with Pfizer.

Something very important to finish up. This guidance has been based on an exchange rate of 1.25 to the dollar, and the sensitivity is 0.6% to a cent, which translates, if I were to take for example 1.20 which is closer to the existing situation, it would be an appreciation by 3% at the EPS level, so I guess that tells you and explains how we came up to that plus 10% guidance for the full year of '06.

Jean-Francois Dehecq - *Sanofi-Aventis - Chairman and CEO*

Thanks, Jean-Claude. Hanspeter for the operations, now.

Hanspeter Spek - *Sanofi-Aventis - EVP Pharmaceuticals Operations*

Yes, good afternoon. I will be accompanied this afternoon by Wayne Pisano for our Vaccine Division, and by Pierre Chancel for Global Marketing. What we would like to share with you is first of all to have a very fast glance back to 2005, to compare our guidance in terms of our sales and performance with what has been achieved. Second, to introduce you finally and completely to the world's leading vaccine company, which is of course Sanofi-Aventis. We would like to have a look with you to the major launches foreseen for 2006.

To the end of the presentation I will come back and give you some insight into our leadership positions in tomorrow's key market of pharmaceutical industry, and last but not least, of course, an outlook of what we expect in terms of performance inside the operations for 2006.

So, first glance then back to 2005. Once again, you will remember our guidance, which has been first of all to have a performance which is in line with the previous year, 2004. Second, a performance superior to the pharmaceutical markets everywhere, and third a performance with the base business which is supposed to be stable.

If you look at this first chart, here you see that evidently we have been growing our pharmaceutical sales and our vaccine sales in total by 9%. You are of course aware that by the end of the last year, in the fourth quarter, we had some accidents in the U.S. in terms of the appearance of generic products especially in competition with Allegra, so if you would take those effects out, our growth would even have been, I admit, in a very virtual way, but our performance would have been even 11%.

You see further from the chart that we had an exceptionally good year in terms of vaccines, which have very strongly contributed to the overall development of the Group with a growth of more than 27%. And yes, last but not least, we have achieved another year where our base business, which still represents about a third of our sales, has been stable. Which means within in our guidance.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Now, from a geographical point of view, as the chart shows we have out-performed in all parts of the world the pharmaceutical market. This is especially true for the U.S. market. You know that the growth of the U.S. market has decelerated during 2005 and as I just mentioned that the appearance of generic products has burdened our performance but nevertheless I find this quite impressive to see. Despite those events, our growth in the U.S. has been nearly twice the growth of the pharmaceutical market.

So I ask now Wayne Pisano to step up and give us his presentation of our vaccine activities in the U.S. and outside the U.S. Wayne.

Wayne Pisano - Sanofi-Aventis - SVP Sanofi Pasteur, Commercial Operations

Thank you, Hanspeter. I have the remote. Sanofi Pasteur is the world leader in vaccines. We produce 1.2b doses in our seven manufacturing sites, two of which are in France, one in the U.S., one in Canada, one in China, one in Thailand and one in Argentina. These vaccines prevent over 20 diseases, and protect over 500m people.

In 2005 our consolidated sales was 2.1b, up 26.9%. This growth was driven by all franchises and across all business units. Our international business unit was up over 15%, our Canadian business unit up over 10%. The U.S. was up over 33%, and our sales to the joint venture in Europe was up 21.6%.

In Europe we have a joint venture with Merck and Company. It's a 50-50 joint venture. Sales were 688b in 2005.

Our sales were driven across our entire franchises and the main drivers were influenza, meningitis and booster vaccines for adolescents and adults.

Looking at our influenza performance, we were up almost 27% globally, with the main driver being the U.S. marketplace, up 35%. Growth was driven by increased demand, the initial production of H5N1 avian vaccine, and by competitors' supply problems that were experienced both in North America and in Europe.

In the U.S. we experienced three very successful launches. The first was a product called Decavac. Decavac is a tetanus-diphtheria vaccine that is preservative-free, and it replaces an older vaccine that contained tetanus and diphtheria that contained a preservative. Menactra is a quadrivalent conjugate vaccine for meningitis. It protects against four serotypes - A, C, Y and W135. The product was launched in March 2005 and generated 179m of sales in its first 10 months.

After mid-year we received licensure for Adacel. Adacel is an adolescent-adult booster for tetanus, diphtheria and pertussis, and in the first five months Adacel generated sales of \$26m.

In terms of influenza, we are the world leader in influenza in terms of basic revenue and manufacturing. We have two main manufacturing sites, one in France, and one in the U.S. Our global capacity for intra-pandemic vaccine is 165m doses, and that is in comparison to a global capacity of 300m for the entire industry.

We expect to see significant growth in the influenza marketplace and have taken the necessary steps in terms of our capacity. We're building a new facility at this moment in time in the U.S., which will increase our capacity for intra-pandemic influenza from 50m to 100m doses, and in France we're putting in place a new filling and packaging facility, which will double our capacity in terms of filling and packaging, which will allow us to deliver more doses faster to the marketplace.

We expect market expansion to occur across all markets globally, driven by a number of reasons. For example, in the U.S. the CDC has a program called 'Healthy People 2010'. Their goal is to immunize 150m Americans. Today, to put it in perspective, 80m to 90m Americans are immunized on an annual basis.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Looking at South East Asia, there's tremendous opportunity that has -- heightened by the fact of the avian flu that's been circulating. Government officials and policymakers have come to the realization that it's necessary to increase the intra-pandemic immunization in order to have the capacity when and if there should be a pandemic. And to give you a perspective on that, in China there are 1.3b people, and today there are 20m people immunized. India, there's 1b people, and there's virtually no immunization for flu. So both of these would be tremendous growth markets over the next 10 years.

We've had very strong collaboration with Governments and policymakers worldwide, as related to pandemic planning and preparedness. We have strong relationships with the NIAID, with HHS, the EU Government as well as the Government in Australia. Michel DeWilde will take you through our pandemic pipeline later in the presentation.

In terms of Menactra, Menactra was launched in the U.S., and this is the first launch for what will hopefully be a global roll-out. We believe Menactra will be a blockbuster, achieving over 1b of sales by 2010. In the U.S. Menactra is indicated for 11 to 55 years of age, and we expect continued uptake in this category in 2006. During the course of 2006 we expect the approval for our supplemental BLA for two to 10 years of age, and we'll launch that indication during the course of the year.

We also expect licensure in Canada in 2006, and we'll launch that around mid-year, and we'll be filing the Menactra BLA for two to 55 years of age in Europe either in the end of '06 or early '07. In addition, our childhood development program, which is designed to take Menactra down in age, under the age of two, has completed its Phase II and is entering now Phase III in 2006.

Finally on Menactra, we are basically in the process of building a new facility which we expect to be online in 2008. This facility will have a capacity of a minimum of 20m doses, and will allow us to take advantage of the global demand for this product.

In terms of Adacel, the adolescent and adult marketplace is one of the growth opportunities in the vaccine industry, and this category is expected to grow significantly over the next 10 years. Adacel is a vaccine that provides immunization for tetanus, diphtheria and pertussis. This is a product indicated for adolescents, from 11 to 55 years of age, and it is a product that is well tolerated because there's lower diphtheria content.

Pertussis, or whooping cough, some people think it's eradicated and in fact it is not eradicated and is on the rise globally. And while the disease is generally mild to moderate with adults, the disease can be very severe with high morbidity and mortality for infants. Based upon this, the ACIP has recommended that all adults and adolescents that come in close contact with newborn children under the age of 12 months should be immunized to stop the transmission of pertussis from adolescents and adults to children. Yesterday, the ACIP recommended that all healthcare workers be immunized as well.

In Europe, we see major opportunities in our joint venture with Merck, and expect business to grow significantly over the next five years. The joint venture covers 19 countries. We have 29 vaccines for adults and 26 childhood vaccines, and have -- are the market leader with a 36% market share. The joint venture is in the midst of an unprecedented period where they'll be launching six new vaccines over the next several years. Last year we launched Pediaxel, which is a polio-pertussis-hib pentavalent in the U.K. and the Netherlands. This has become the standard of care in the U.K.

We'll be launching ProQuad, which is a combination of measles, mumps and rubella, and varicella, and this combination will help increase immunization rates, particularly for chicken pox, throughout Europe. This will be followed by three launches from the Merck pipeline - Gardasil, which is HPV, RotaTeq for rotavirus, and Zostavax for zoster or shingles. This launch period will culminate with the launch of Menactra, which again will be filed late this year or early in 2007.

The vaccine marketplace is expected to double over the next five years. By 2010 we see the market reaching 15b. This growth will be driven by new vaccines which include Menactra, the boosters such as Adacel and [Repravax], HPV, rotavirus, zoster and new flu products. We expect to see growth beyond 2010 due to the fact that there are a number of unmet medical needs, such as diseases for dengue, malaria, the [staphoriates], HIV and cancer.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Sanofi Pasteur is well positioned for growth. We have a leadership position in influenza, meningitis and boosters, and are doubling our capacity to take advantage of these opportunities. We will be launching two pentavalent polio-pertussis-hib products in the U.S. and internationally over the next several years. Pentacel, which is similar to Pediacel - that's what was launched in the U.K. - will launch in the U.S. in 2007, and Pentaxim will launch internationally in 2007 and 2008.

As you'll hear later, we have a very promising pipeline. We're making the necessary investment to expand our capacity to meet the growing needs, and we will share all the key drivers with our own portfolio or through our joint venture with Merck. We have a very strong relationship with the policymakers globally, such as Unicef, WHO, CDC, and the bottom line is we are very optimistic about the vaccine marketplace and about Sanofi Pasteur's future in growth.

Thank you.

Hanspeter Spek - Sanofi-Aventis - EVP Pharmaceuticals Operations

Thank you, Wayne. Let me now guide you through the launches of 2006, the intended launches. You should note that all of those products I will present to you have been deposited this year, so it is some of them are already approved, others are in the process of getting their approval.

So let me start with Ambien CR. You may remember that we had received an approval letter for Ambien CR in April 2005, and subsequent to this, having had then obtained an approval in October 2005. The first results of Ambien CR, as you see from the chart, are entirely satisfactory. I think they are even impressive. On the left side of the chart you see the penetration of the product compared with two benchmarks of the industry, one Nexium the other one Paxil and you see evidently that the penetration is faster and higher.

On the right side of the chart you see the second positive effect of this launch. You see that after months of stagnation and also an impressive first in-march of a new competitor in the market, that this has changed. The competitor is no more really growing, and you see that the overall portfolio of Ambien came back to a very solid growth.

I can report to you that the prescription growth for the month of January 2006 is about 14%, which means we are really back to growth rates we had last seen in, let's say, mid-2004. So I can only add to this, and also this has been recorded by us during the last quarter, we have received the [regress] from the Federal Drug Agency, who perform clinical trials in pediatric use of Ambien, which is a hopeful first indication that there may be even a longer period before the product will not become accessible to generic competition.

Second product we have already launched in Germany with significant success. This has been reported in previous sessions. This is Apidra. Apidra goes in the fast and vastly growing market of diabetes. We are today in the launch of Apidra in the U.S. All the other European markets will follow step by step, and of course we are very much encouraged by this success. We have so far [obtained] this Apidra in Germany, which was not at all hindered by parallel introductions of competitive agents from other companies.

If you look to the overall market segments of diabetes products, you see that Apidra, which is accompanied by its big partner Lantus - by the way, Lantus became our eighth blockbuster during 2005, still very, very impressive growth rate of 50%, approximately, in 2005. So in short, that's the Lantus market then the Apidra market are the two markets really driving the overall diabetes segment, so in very short terms it is the good place to be and we are happy to have the two adequate products to continue to drive those market segments further.

Third important project in terms of launch in 2005 is, finally, Plavix in Japan. The Plavix has been finally approved in Japan and we are today in the final negotiations to obtaining price and reimbursement in Japan. This has been a very long process. We have used this process on the regulatory side in redefining our collaboration with our long-term partner, Daiichi. As you know,

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

we have obtained 100% of the rights to market Plavix in Japan, which changes the flow of the economics in a very substantial way and it is in our favor.

We go today in a fast-growing market segment. You see that the antiplatelet agents, in terms of treatment, these are currently growing by 33%. This is a market which has not seen any innovation for many, many years. This makes us equally optimistic, as of course, big franchise Daiichi has acquired, during many, many years with [ticlopidine], the predecessor of clopidogrel.

Firstly we believe this is a long-term opportunity. Consequently we are very active in lifecycle management. We intend to expand the usage of the product in the direction of acute coronary syndrome as of 2007 or 2008, so to make it short, yes, we have important ambitions for Japan and we think that on the long run, Plavix will become a Japanese blockbuster for itself.

Before finally going through the Rimonabant, as I'm sure you are eager to hear more on Rimonabant. Nevertheless, another product which tends a little bit to be overlooked, Multaq dronedarone as INN. Multaq goes into a very important, very strongly growing market. The market of arterial fibrillation.

Why is this market growing? You see it from the chart, as the first indications the disease is largely related to age, and we see growing age within the aging pyramid of the Western countries. It is clear that this market will significantly grow in the upcoming years.

We have deposited the Multaq file in June 2005 and the first reactions of the FDA are imminent for the next weeks or months. On the overall development from a clinical point of view, [indiscernible] will make some comment in a couple of minutes.

From this chart you see very impressively what the market potential will be over the next years. You see that there will be more or less tripling the market between 1999 and the mid-2000s, as a consequence to what has indicated before, aging pyramids. And on the other side we have a market which is by far not satisfied. All those products which are currently on the market have [is a] problem on the efficacy side, or on the side effects side, in the sense of organic toxicity or even of both sides. And we believe to have this dronedarone Multaq a product which will meet this market in a very impressive manner.

Now last, but definitely not least [technical difficulty] Pierre in fact has become a true specialist for this exciting drug. So, Pierre.

Pierre Chancel - Sanofi-Aventis - SVP Global Marketing, Pharmaceuticals

Thank you, Hanspeter, and it's my pleasure to present Rimonabant today.

First of all let me start in framing the scope of what we are talking about when we speak about cardiometabolic risk, abdominal obesity and related commodities.

Everything starts with abdominal obesity, and speaking about abdominal obesity, this is this fat, this visceral fat around the abdomen, and when you have fat in excess what does happen is that it's not any more a storage organ, but abdominal fat becomes a real endocrinal gland, that triggers a cascade of bad events or bad secretions, if you want, that lead to an increase of the cardiometabolic risk, such as dyslipidaemia, low HDL and high triglycerides. Such as insulin resistance, leading to diabetes and such as inflammation, and inflammation, you know, is involved in the arterial genesis.

Speaking about abdominal obesity, I need to give you the cut-off, and the cut-off according to the American guidelines are 40 inches for the man and 35 inches for the woman. Which means that, going to the next slide, you can see that, in terms of epidemiology -- on an epidemiological standpoint, we are talking about, according to the last wave of NHANES, which is wave four, we are talking about 100m American adults that suffer from abdominal obesity.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

The second point is that this abdominal obesity is not alone, because there is a lot of related co-morbidities, such as hypertension, such as diabetes, and dyslipidemia. And the point is that if we put things in perspective for abdominal obesity, for instance, these -- according to the last wave which was NHANES 3, was concerning one third of the adult American population, and the last wave concerned one out of two, 50% of adult Americans. When you consider diabetes, it's almost the same figures so which means that, unfortunately, the physiopathology is very well connected with the [inaudible].

Now, looking at the next slide, this to me really makes the point about the fact that we should consider not only the single risk factor such -- or individual risk factors such as obese -- such as diabetes or dyslipidemia, but we should really now consider a global approach, a comprehensive approach in terms of morbidities, such as these morbidities that we can find in the cardiometabolic patients. Same thing for the management of these patients, and it legitimates actually one point, which is the fact that we have to take it as a comprehensive approach.

The last point, but not the least, is that when we consider the [inter heart] better, inter heart that have 15,000 patients, you can see that when these metabolic risks occurs in the same population or in the same patient, the risk is not simply -- or the total risk is not simply the addition of all these risks, but it's exponential which makes even more dramatic the problem posed by or caused by these metabolic factors, or cardiometabolic factors.

Then last, let me call or let me talk about Rimonabant now, and I will summarize the RIO program and in the RIO program is four studies, RIO Europe, RIO North America, lipid and diabetes. And this program involves almost 7,000 patients. And the beauty of these trials showed that, first of all a great result that I will comment, and the second thing is a very consistent data across the four studies.

So what you find is obviously a decrease of abdominal obesity, obesity and abdominal obesity, and the related co-morbidities, such as a decrease of diabetes and improvement of lipidic parameters, but also hypertension parameters. This is one point.

The second point is that, beyond this weight loss effect, we were able to show and to demonstrate a 50% additional effect beyond weight loss, which is absolutely unique. This is true for the diabetes parameter, 50% additional decrease of HbA1c which was not weight-related and 50% improvement of the dyslipidaemic parameters, increase of HDL, decrease of triglyceride, which were not again weight-related.

The explanation actually is about the special and unique mode of action of Rimonabant CB1 blocker. In the abdominally obese patient, the CB1 system is over-activated and Rimonabant actually is putting down or putting to a kind of normal way, the CB1 system, which means that you get to -- or you get back to normal.

Then, if I comment just a little bit [that adds up] all the figures, the intra-abdominal decrease was about 10% and you have to consider that 10% of abdominal decrease represents 30% of intra-abdominal fat, which is actually the bad fat if we oppose it to the periphery fat.

Now the diabetes parameter, almost 1%, 0.8% decrease of HbA1C and 15 to 20% increase of HDL and a 15% decrease of triglyceride, which means that with this product you have a unique compound for the first time, actually, managing cardiometabolic risk on a comprehensive way and bringing several advantages on multiple cardiometabolic risk factors.

Now, let's think a little bit about the future because we got some great data on the RIO program. So the reason why we wanted to have a complete and very comprehensive lifecycle management program that could enable us to leverage this product or the data for the full benefit of the patient in all the components of the cardiometabolic's risk.

Program Ambitious, that is based on two dimensions, first the metabolic dimension and the cardio dimension. The metabolic dimension, if we consider diabetes, so we will target three populations. One is the Serenade study with the first line diabetes. Second is the Arpeggio study involving inseminized patients with Rimonabant. Third one is the Rapsodi study involving pre-diabetic patients defined by IGT, impaired glucose tolerance.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

So this is for the diabetes program. The dyslipidaemic program is the Adagio program and, if I go to the second dimension which is the cardio one, one will be the [plaque], plaque stabilization, with the Stradivarus and Auditor studies and, last but not the least, actually, the big M&M, morbidity and mortality study, that ultimately is aiming to show a reduction of cardiovascular morbidity and mortality using Rimonabant. So, a very complete and comprehensive lifecycle management program.

Now, let's go back to the data and get back to, let's say, what we have now and, actually, I'm very proud to see the publication actually we got with this RIO program. RIO Europe Lancet, RIO Lipids New England, RIO North American JAMA, four really prestigious medical reviews that clearly show the interest and the recognition that the medical community, not only for the area or so for the disease, but also for the product and the data. And this led to the amount of, huge amount actually, of oral presentations, posters and abstracts.

When we try to compare what it means after some of the launch, so we got the [pre-med] database and you can see on the slide that, actually, the number of Rimonabant publication is not ridiculous at all.

Now, this is what we have done and what we do in terms of activity, but let's speak or start to speak a little bit about the outcome. And, regarding the outcome, it's about Rimonabant awareness in the U.S., so this is a U.S. database, amongst GPs, cardiologists and endocrinologists, and you can see a massive improvement between 2004 and 2005 in terms of Rimonabant awareness.

[Obviously] this increase or this awareness is greater in the specialist, or at the specialist level but it's quite normal because, for the time being we have been really communicating at the key opinionators and the specialist level.

Now, I have to say one thing that it's not those specialists that were involved in any Rimonabant program. These are specialists, randomized specialists or GPs that you can find in the U.S., so these are real data representing the real awareness of Rimonabant in the U.S.

We are working, obviously, beyond the involvement and big energy that we put in participating to AHA, ADA or EASD or ECC, the big congresses, the worldwide congresses. We are also running some programs like the Submit, on cardiometabolic risk. So this year, 2006, will be the third edition of the cardiometabolic Submit. Goal is with 1,000 key opinionators worldwide, to really work on the development and the knowledge of the cardiometabolic risk and the new approach in this area.

Another thing which is what we do at the patient or public level, and an example is the World [Out] Day, so shape the nation [after] September 2005, sorry, and we'll do it in 2006. And then the goal is still the same, to make sure that there is a good understanding and knowledge about cardiometabolic risk, but then it's a different audience. So it's TV, it's radio, it's newspaper, it's thousands and thousands of patients that were exposed to, during this day, were exposed to cardio -- the knowledge of cardiometabolic risk and so took their waist perimeter. So you see, a point and the opportunity to start to really increase awareness about the cardiometabolic risk.

Last, but not least, let me show you the provisional launch schedule and you see a period in the U.S., in key countries and the rest of the world. And let me finish in conclusion, just two or three things.

Point one is that the disease is there, morbidity is there. A huge number of patients are freeing from cardiometabolic risk and this abdominal obesity, with related co-morbidities. So this a problem and we need to do something about it.

The second point is that we have a fantastic product with Rimonabant, that for the first time and I insist for the first time, was able to demonstrate a unique mode of action, so a unique benefit in being able to address multiple cardiometabolic risks factors with one single agent.

And, I would say last but not least, it's about our ambition, ambition to deliver and do the best for, not only the product but, obviously, for the patient, because we are convinced that this product, if we put the right level of energy at the physician level,

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

at the patient level and at the payer level, we'll be able to change and re-define the way cardiometabolic risk will be managed. Thank you.

Hanspeter Spek - Sanofi-Aventis - EVP Pharmaceuticals Operations

Yes, hello again. So before closing I would like to draw your attention to a part of our geographical reporting which is usually called rest of the world, a nomination which is probably not adequate for many angles.

You know we said this part of the world has been an important part of our Company strategy from the very beginning, in line with our leitmotif 'no small countries'. We believe that this leitmotif became even more important during 2005 as a consequence to the obvious slow-down of the growth of the American market.

So where do we stand? First of all, perhaps, let's go back to 2005 and, as you see from the chart, already in 2005 this part of the world, rest of the world so to say, has contributed in an important and impressive manner to our overall growth, nearly 0.5b of sales. In other words, approximately a fourth of our overall growth in 2005 came from those markets.

If you look to a sub-segment once again which became rather popular with the abbreviation BRIC, Brazil, Russia, India, China, you see, of course, the very well known differences on one side. Yes, it is true that this market today still represents only 3.5% of pharmaceutical industry sales. But on the other side, yes, it is also true it represents about 43% of the world population, and it's fair to say that a number of problems our industry has comes exactly out of this disproportion.

Nevertheless there is change. If you look to the left side, the bottom of the chart, you see that those four markets alone already today present 17b of sales and what is even more impressive is the strong growth, the strong growth which is, in 2005, about 2.5 times the growth of the world pharmaceutical market.

Now where do we stand? We have a very good position. As you see, we are the leading Company in those BRIC countries and, even with some distance to the second leading company. What is further encouraging, we have a market share of 4.5%, which is approximately one point below our world market share which means, despite our first position, there is significant opportunity for even immediate growth, only by stepping up in those markets to the usual level we have within the pharmaceutical industry.

To get there what do we do? First of all, yes, we invest. We invest in our commercial structures. We have increased our presence in terms of reps in those four markets during the last year, by 30% and we count today 4,000 reps in those four markets only and, of course, China plays a very important role within.

But even more important we have a local approach, because those markets, besides the common abbreviation, they have, in fact, very little in common. So we feel they have to be approached with local strategy, but always with an integrated strategy in all those countries. We are present in research, we are present in production and, yes, we have huge supplementary opportunities, complementary opportunities, by the combination of the vaccine business with the pharmaceutical business, and we believe that this is another very important advantage for this Company.

So let me summarize what is the outlook from operations for 2006. First of all, we believe that 2005 once again has been another year which is building a very, very solid basis for the following year, 2006, in this case. In 2006 we believe that our growth will continue to be driven by [directions] of cost, but also by numerous opportunities coming from the new products which I could point out to you.

We will continue to drive our base business and we are convinced that we will continue to have relative stability with this base business despite unfavorable interventions, for example, in terms of price reductions, but we are convinced that we will stabilize -- continue to stabilize products, at least on a volume basis.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

And last, but not least, I believe I was successful in showing you that we have a very, very good starting point in those future growth markets as [the free segment] and, yes, we will also take advantage of this and this, overall, makes us very confident for the ongoing year 2006. And I thank you for your attention.

Jean-Francois Dehecq - *Sanofi-Aventis - Chairman and CEO*

Thanks Hanspeter. Gerard, for R&D.

Gerard Le Fur - *Sanofi-Aventis - SVP, Science and Medical Affairs*

Hello everybody. As you know we have 129 products under development but maybe more important, we have 55 products in Phase II and III. One year ago we had 48 products in Phase II and III, meaning that we were able to accelerate the development of our compounds. Don't forget that we have 18 compounds in Phase IIb and 17 compounds in Phase III.

So, Michel DeWilde, who is the R&D boss of vaccines in Sanofi Pasteur and myself we'll go through the seven areas. Let me start with the cardiovascular area.

Apart from dronedarone that we filed last summer, we have four compounds in Phase IIb, two for PAD, one for atrial fibrillation and one for hypertension and diabetic nephropathy.

Dronedarone, the action date is April this year and 40% of the patients were required in the Athena clinical trial, meaning that we are on track for the huge clinical trial with dronedarone. Dronedarone is a compound which is administered by IV. SSR149744, which is in Phase II an atrial fibrillation and which is a back-up of dronedarone, is administered once a day. And, as you can see here, we finished the recruitment of the Phase IIb trial with this compound in atrial fibrillation for those versus placebo and amiodarone as a calibrator. In other words, we'll have the results of this Phase IIb by the end of this year.

Two compounds then enter Phase IIb. AVE7688 in hypertension and SL650472 in PAD. This compound is a sedative antagonist of 5HG1b and 5HG2 receptors. These compounds possess anti-platelet activity, antiviral conflictive activity and anti-proliferative activity. We just initiated a Phase IIb study with these compounds in PAD.

XRP0038 that was tested in PAD, the results of this Phase IIb study will be presented at the ACC this coming March. This compound is a gene therapy with FGF and we tested it in very critical patients with critical leg ischemia. Thanks to the introduction of the gene of FGF, we were able to stimulate the production of vessels, in other words, to stimulate [angio genesis]. One more time, these results will be presented at the ACC, March this year.

And we plan to start a Phase III study before the end of the year, versus placebo one more time in critical leg ischemia, the primary endpoint being amputation and death. Here you have the results of AVE7688 in hypertensive patients. This compound is definitely active starting at 10mg but, as you know, with such a compound the key issue is no more efficacy, it is safety, so this is why we just initiated a very large, broad-ranging trial with more than 700 patients [for this was] tested versus [iosartan] and with the long-term safety assessment of one year.

A few words about thrombosis. You all know that, in 2006, we'll have quite a few of results in this area, but I will mainly focus my presentation in thrombosis on the so-called biotinylated idraparinux, SSR126517, that is artificially put in Phase IIb right now, and I will explain to you why because we've started Phase III studies with this compound before the end of the year, and the last time you saw this compound it was only in Phase I. In fact, it is a totally new and totally innovative approach and I'll try to explain to you why.

So as you know, and as already mentioned by Hanspeter, we got the approval of Plavix in Japan and the Charisma results will be presented at the ACC in March. Moreover, the Extract results -- the results of the Extract trial on Lovenox will also be presented

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

at the ACC in March. The Van Gogh program of idraparinux will be presented at the ASH before the end of the year. And, as I mentioned to you, the biotinylated idraparinux, SSR126517, the Phase III study will start second quarter of this year.

All the anti-thrombotic agents, all the anticoagulant agents have roughly the same main side effects, which is bleeding, and it's not so easy to get an antidote versus this bleeding. So, we got the idea to introduce a "hook" on the compound that might allow immediate "fishing" and rapid elimination of the compound in case of bleeding, and it's particularly important when you have a compound that you want to administer once a week with a very long half-life. But, for sure, the hook should not impair the interaction between the pentasaccharide and ATIII. This hook should not impair the interaction of this complex pentasaccharide/ATIII with the factor Xa and, for sure, the hook should allow quick and efficient fishing.

You have here, roughly let's say, schematically, the chemical [circle] of this compound, idraparinux, a spacer and biotin, no chance for the link with ATIII and for the link of this complex with anti-Xa. And thanks to Avidine, which has a very important affinity for biotin, this association will lead to rapid elimination of the compound. So in fact for this synthetic oligosaccharide which carries biotin [moiety], we have exactly the same sequence as idraparinux, the same anticoagulant activity as idraparinux in vitro, a very high affinity for ATIII, a strong and specific inhibition of factor Xa, no HIT reaction, the same pharmacokinetic properties as idraparinux whatever the species we tested, leading to once-a-week administration and I will present to you the comparison of the pharmacokinetics of the biotinylated idraparinux with -- to idraparinux in humans.

This compound has the same anti-thrombotic activity as idraparinux in pharmacology, especially for the prevention of venous thrombosis and, like idraparinux, a low hemorrhagic effect. Moreover, biotin is covalently bound to idraparinux, and this leads to a strong and specific affinity for Avidin versus the antidote.

So here you have the comparative pharmacokinetic of biotinylated idraparinux versus idraparinux in human volunteers at equimolar dose and, as you can see, really the pharmacokinetic profiles are superimposable, no difference at all. And again, whatever the species we use, with biotinylated idraparinux and idraparinux.

The antidote is an injectable protein. Avidin binds to biotin with a very strong affinity, 10-15M. No other ligand has been described so far. This antidote Avidin is devoid of any pharmacological activity, especially no pro-thrombotic activity. It is rapidly eliminated by IV injection, for instance, the half-life is around two minutes in rats, and this injection of Avidin leads to a quick elimination of the bound biotinylated idraparinux from the circulation and that's what I will show to you in this slide.

Have a look on the right part over a 12-hour period. Avidin infusion leads to a dramatic and very rapid neutralization of the factor Xa activity, as you can see roughly 90%. We administered 9mg of biotinylated idraparinux, which is the triple of the potential active dose, in other words, trying to mimic a possible bleeding. And again, one more time, 100mg of Avidine leads to a rapid and large neutralization of factor Xa activity, and have a look on the left side, without evidence of any rebound.

So right now, thanks to a bridging with idraparinux development, thanks to the Van Gogh program and following a kind of end of Phase II meeting with the authorities, we start the first quarter this year a bioequipotency study with idraparinux and the biotinylated 3mg idraparinux, and the second quarter of this year, a clinical study in patients with pulmonary embolism and DVT, double blind versus warfarin. One more time, I'm sorry to insist a little bit, this is definitively a very innovative and totally new approach for a new type of compound for new anti-thrombotic agents.

A few words about CNS. This is certainly, or possibly, the richest part of our portfolio and, as you can see, we have six compounds in Phase III and two compounds in Phase IIb. And most of these compounds are first in class and this is also the case for compounds in early development. There is not enough time to comment too much on these compounds.

As mentioned by Hanspeter, we received a written request for pediatric indication coming from the FDA and pre-clinical and clinic programs are ongoing, that is to say toxicological studies in juvenile animals and clinical trials in patients with ADHD which suffer from insomnia.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

We have, as I mentioned to you, six compounds in Phase III, two in neurology, two in psychiatry, one in sleep disorders, one in smoking cessation, four of them being 13+. We got one negative result in Alzheimer's disease. We were unable after 12 weeks' treatment to get back any increase in memory of patients treated by SL650155, so we decided to stop the development of this compound. And I will present to you a positive result in Phase IIb in sleep disorders with M100907.

Like eplivanserin, this compound is a 5HG2A receptor antagonist. This compound induced [slowest] sleep, induced let's say the good sleep -- an increase in the good sleep. It's a qualitative effect on sleep. And we performed a four-week double-blind, placebo-controlled randomized study, three doses versus placebo and we got two types of measurements - polysomnography and patient-reported measurement.

And, as you can see in the next slide, by using objective measurements, that is to say polysomnography at 2mg, this compound decreased the number of awakenings and increased WASO -- and decreased WASO in a very significant manner. Subjective measure decreased WASO and even increased total sleep time. So, that is to say that, one more time we validated the hypothesis of the effect of 5HG2A receptor antagonist on sleep maintenance insomnia at 2mg per day, four-week treatment, M100907 decreased WASO and the number of awakenings. It improved day-time functioning and does not induce any re-bound or residual effect the day after. And this compound was very well tolerated.

A few words about oncology. We have four new [chemotherapy TT] in Phase III, tirapazamine, XRP9881, a new taxoid compound that was currently tested in patients which are resistant to taxoid administration, either in monotherapy or in association with other agents. Alvocidib, we mentioned to you that following results for a new regimen obtained by NCI, we are currently starting a Phase III study in CNL, especially in resistant patients. And we have xaliproden, which we already mentioned to you last time, the effect of this compound of the protection on neuropathy induced by oxaliplatin. It was, for sure, quite important for the patients which were treated by oxaliplatin, but it was also very important study for xaliproden, showing that this compound was neuro-protective in humans.

Also on tirapazamine, you know that it's a unique mechanism of action. This compound is more important in cells which are under low oxygenation. That is to say that it is more potent on cancer cells than on normal cells, that's why we are testing this compound in radiation in association with cisplatin in head and neck cancer. The first study, all the patients were recruited, and we'll have the results by the end of this year. For the second study [250] patients were approved.

We got one negative proof of concept study in small-cell lung cancer. This is a very small indication and the truth is we were unable to detect activity of meclizine in a very small sub-population of patients that you were unable to describe, so we decided -- and to identify, so we decided not to go on with this compound.

And finally, the second Xenox study with xaliproden already started. But I just wanted to talk a little bit more on VGF Trap, the compound that we could develop with Regeneron. With [antiandrogenic] agent, this hypothesis was, for sure, validated by compounds like Avastin and, you know, we have very, very good results in Phase I. For sure, these are open studies but you know we got, even in safety, very few hypertension, only grade two and very few. And we got a penalty in very resistant patients.

You know that in Phase I we have always resistant patients. Very impressive results with this compound, even in monotherapy, which leads us to extend our collaboration with Regeneron to Japan. And our friends from Regeneron will present to you very soon more data on VGF Trap. Yet again, we try to speed up as much as we can because apparently this compound seems to be very efficient and, for an anticancer agent, very safe.

Metabolic disorders, for sure I will say a few words around Rimonabant. I just also would like to add that we have two compounds in Phase IIb, a GLP1 agonist in diabetes and a back-up of Rimonabant, and I will present results with this compound.

So as you know, in the non-approvable letter that we received on Rimonabant, the FDA asked us to perform an additional clinical study in smoking cessation. But in the approvable letter, no additional trial in obesity has been requested by the agency and we will meet the FDA in the coming weeks to address all remaining issues. And I'm pretty sure that you will understand

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

that we'll not comment any more on Rimonabant because we first need to meet the FDA and to work with them on the Rimonabant dossier.

As I mentioned to you, I will present to you positive results with another CB1 receptor antagonist, the SR147778. To my knowledge, it is the first time that another compound, apart from Rimonabant, will present efficacy in a Phase IIb study. Moreover, as we mentioned here to you, AVE0010, a GLP1 agonist, entered Phase IIb. We could develop this compound with Zealand Pharma and will compile four doses versus placebo, BID versus QD, with a classical primary endpoint which is HbA1c.

Here is the protocol on this Phase IIb study that we performed with the second CB1 receptor antagonist. It's rather classical, a little bit different of a Phase IIb trial that we performed with Rimonabant, but roughly as you can see here, at 20mg this compound, both on weight changes and on weight circumferences and weight circumference changes, seem to be roughly similar to Rimonabant.

However, there is a qualitative difference. This compound is less active than Rimonabant on cardiometabolic parameters, such as HDL, triglyceride or HbA1c. So a qualitative difference in efficacy, possibly this compound is less peripheral than Rimonabant. Concerning the safety profile, definitively this compound seems to be similar to Rimonabant. As you can see here, patients with any adverse events, roughly 72% in placebo, 68%, 20mg SR compound. Serious adverse events, 4.8% placebo, 3.8% the SR compound, and patients -- discontinuation due to adverse events, 7.2% under placebo, 14% under SR.

And the reason of these discontinuations were similar to Rimonabant. As you can see here, the main side effect of this compound are GI disorders, diarrhea and nausea, or some CNS effects such as insomnia and dizziness. And, in fact, the discontinuations were linked to both -- either GI disorders or CNS side effects. So, one more time, this is the first time that another CB1 receptor antagonist presents activity in obese patients. One more time, it validates the blockade of CB1 receptors, although we got some qualitative difference on cardiometabolic parameters. One more time, this compound seems to be less peripheral than Rimonabant.

A few words about internal medicine though, as you know, we could develop with Altana, Alvesco and our friends from Altana will comment on the ongoing study that we have with Alvesco. And, concerning the Phase IIb, with the association of Alvesco with ciclesonide with formoterol, we do hope to have the results of this Phase IIb before the end of this year, but I will focus my presentation mainly on the V2 receptor antagonist. But I just would like to remind you that we got the approval for fumagillin in France for microsporidiosis, which is an orphan disease [covering a huge area] for patients who suffer, for instance, from AIDS. For sure, it's a niche market but we are very proud to be able to help these people.

So here I will present to you positive results of this compound in SIADH, in syndrome of inappropriate expression of antidiarrhetic hormones. And you can see here that in this euvoletic situation, the response rate of the placebo of both studies was between 11 and 13%, with our V2 receptor antagonist, it was between 80 and 90%. So a huge effect, as I previously showed to you in other clinical trials.

But if we consider the serum sodium, we got exactly, for sure, the same results, no significant effect under the placebo treatment and always a very positive effect on sodium serum with the V2 receptor antagonist, both at 25mg and 50mg once-a-day administration.

So, don't forget that this dilutional hyponatremia is under-diagnosed and under-treated, and you have more [by the end of the book] concerning dilutional hyponatremia. Our V2 receptor antagonist significantly corrected this hyponatremia in all the populations, whatever the underlying diseases - CHF, liver failure, SIADH or mechanism euvoletic hypervolemia. So we'll file these compounds before the end of this year for these clinical indications.

And if you don't mind, I'll stop right away and my friend, Michel, will go on with the vaccines.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Michel DeWilde - Sanofi-Aventis - SVP Sanofi Pasteur, Research and Development

Good morning. This slide depicts our current pipeline for vaccines with 21 products in development and one more at the registration stage. As alluded to by Gerard, there were positive movements in the Company pipeline overall, and this is also true for vaccines since we have 10 products moving along in the value chain. Today I'll opt to describe very briefly two -- three areas. One is a combination vaccine for infants. The second one, inevitably, is influenza but I also want to touch a word on our dengue vaccine project.

Our prospects for 2006 are to move 10 products through the value chain. Wayne alluded to a couple of instances, especially in the meningitis field in terms of moving, for instance, the [inaudible] up to Phase III. The other two are products that we move to Phase III this year are related -- are, actually, in the influenza field where, obviously, we want to maintain our global leadership.

In terms of line extension, my second management, we are looking at the two extremes of each range. We are looking at the possibility to fulfill the un-met medical need in the young infants, six weeks to six months of age. On the other hand we are looking at improving efficacy of the vaccine in the elderly ISC population and, as a matter of fact, during 2005 we could demonstrated a new formulation actually increases an immune response in this population and we'll move into Phase III this year.

In December we announced our collaboration with Becton Dickinson in what we call the micro-injection system, with the willingness to move away with traditional intramuscular injection in order to both improve patient convenience and effectiveness of the product.

We've been, actually, working on this for a couple of years with Becton Dickinson having chosen flu as our primary target and this program, actually, which is exciting, has been going quite well and we will initiate Phase III also this year.

Last, but not least, in terms of new manufacturing technology that is replacing embryonated eggs production system by tissue culture system. This is a technologically challenging project, but we believe we have taken the option with the most potential, having partnered with Crucell and the PFC6 [second line]. As you may know also, this program is supported by the U.S. Government. We are on track with the program entering the clinic, with both a classical and world inter-pandemic trivalent vaccine, as well as a pandemic prototype vaccine later this year.

Talking about pandemic, I'd just like to point out that the first two clinical trials conducted with an actual H5N1 prototype vaccine was conducted with vaccines that we produced, either by the National Institute of Health with our prototype vaccine produced in [Sisport], Pennsylvania, or our own development using antigens produced in our [Val de Hoetz] in France, which we conducted clinical trials that indicated safety that, not unexpectedly for a naive population, two doses are required for an optimal response. And the highest dosage tested with aluminum gave responses in 60% of the subjects.

And the next step for this particular one is to go on into Phase II and then file from their a mock-up dossier with a European agency. There's a process that they have actually designated but it's extremely important towards the work on reducing the actual dosage needed in order to be able to provide, in the case of pandemic, an appropriate capacity, so dose-sparing activity and we will be very active on that this year.

In terms of combination vaccines, I'd like to point out two of them. Pentacel, for the U.S. market, that was filed mid-last year. It's a very substantial file. Beyond being as efficacious as the individual component, an important point for combination vaccine are the safety profiles and, in particular, we were very attentive on fever, since this had been a concern for some of this type of vaccine, as you can see from the chart there. In terms of Pentacel there is no difference between the actual combination vaccine and the individual component. So I think it's a very strong point for this vaccine.

On the other hand, and we are now addressing the international market for which we are developing, and we are actually in Phase III at the moment, a combination vaccine that would include acellular pertussis and HepB balance but, most importantly,

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

an inactivated IPV balance. This, in line with our preparedness for the time where polio will actually be eradicated, time after which the use of live vaccines or PVs will not be appropriate anymore.

In terms of dengue, maybe a less known disease, yet a very significant medical need. There are over 100 countries affected by this family of virus that's actually transmitted by [inaudible], namely, mosquitoes. The fact that the area where the specific species of mosquito that carries -- that can transmit the virus is actually larger than the endemic area brings with it the risk of further expansion of the disease epidemiologically.

It's a very delicate vaccine to develop. We need to induce long-lasting immunity against four serotypes, which leaves the [inaudible] field to develop -- or attempt to develop live vaccines for this. With live vaccines comes the delicate balance between efficacy and [innocuity], and this was after several years of development research to opt for the Chimerivac technology from Acambis which takes advantages of the well-known profile of yellow fever as a backbone, and this truly we believe is the appropriate technology to effectively achieve this balance between safety and efficacy. We have positive Phase I data and we have entered Phase IIa with our candidate vaccine towards the end of last year.

Lastly, collaboration and partnerships are an integral part of the way we do business and the way we do research and development. Starting if you will, from the bottom of the list which also represents the most [upstream] in the pipeline. We have an agreement with Agensys in terms of identifying tumor associated antigens for our cancer vaccine program. We've made a [steady] partnership with EISAI about the very interesting compound, a so-called toll receptor agonist, which is an adjuvant for cellular -- cell mediated immunity, which is very relevant in a number of our projects, most of them in the most upstream part of our pipeline.

I think we've communicated abundantly on interaction with the U.S. Government in the field of pandemic preparedness. And finally, I mentioned it earlier, agreement with Becton Dickinson which goes beyond flu. It's covered many fields and we are especially excited with this partnership, because we see in it there's a true opportunity for a paradigm shift in the way we -- in the way immunization is both perceived and efficacious. So on this, I will give the word back to Gerard.

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

As a small and quick conclusion, let's have a look on the calendar of the planned submissions. Let's say, before the end of 2008, we'll be able to file 11 new chemical entities and seven vaccines. In fact, concerning vaccines, it does not include the vaccine that will be launched by our joint venture with Merck in Europe and that were presented by Wayne previously.

Concerning the new chemical entity, it does not include the line expansion that you have in the next slide. So, in other words, starting from these 11 new chemical entities, if we add the three that were already filed, dronedarone, Rimonabant and ciclesonide, that means 14 new chemical entities. Plus the seven vaccines, around 20 filings and even if we apply, let's say, a classical attrition rate of 50%, that will mean that we'll file 10 -- we'll have 10 submissions before the end of 2008.

And for that reason that makes us very optimistic about the future of the pipeline of the Company. And if you don't mind, I will stop right away. Thank you for your attention.

Jean-Francois Dehecq - Sanofi-Aventis - Chairman and CEO

Thanks Gerard. That's the line expansion. So, just to close this long speech and [inaudible] presentation, and to give you the opportunity of taking the floor, I will just go back to some figures. Remember two years ago and just at the moment of the launch of the bid on Aventis, we promised you a certain number of things.

The first one was to push a strong growth. I think that '05, which is the first complete year of this merger with a net sales increase by 9.3%, despite the fact that we lost the petition on [Allia] during the last quarter, is something which is on line with our target. You understand that our growth was ahead of pharma market in all the different regions.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

You understand also that the re-launch of the vaccine sales was very important, with more than 25% of growth in '05, that's a big success, and after some other launches. The second point was, not only a strong growth, but a sustainable growth. And for that we need the success of research, it's clear, and we have a long presentation of our portfolio and the fact that we have now 55 products in Phase II and III in place of 48 last year is a very positive sign.

The second point was to increase -- to continue to increase, to re-enforce the sales team all around the world, and especially in the big growing markets and that's what we have done during '05. And also, to invest in some production and, for example, it's necessary -- it's not enough to say that we'll double the size of the vaccine business in the next five years, we need also to prepare this story by investing in production in vaccines. That's what we have done in '05.

Third point, we say that that we need strong, sustainable and profitable growth and, if you look at the figures, it's clear that the earnings per share, with 26% this year, a growth of 26% this year, after 18% in '04. The fact that we are close to 90% of our cumulative synergies, so we delivered the synergies quicker than expected. Other important point also is the fact that we reduced, again, debt from more than 14b to less than 10b, and that's something which is important for the future but also for the health of the Company.

So, I think that -- excuse me, okay. If I'm looking, I don't go back to what we said about '06. I think we can answer your question on our targets for '06. But, if we are looking at '06 to '10 yes, I read like you, that the environment is tougher and tougher, that the pharma business is more and more difficult and so on. But what is clear is that this market retains enormous potential.

And the reasons are the healthcare needs in many, many therapeutic areas. We have some of them on this slide. You see that we are in all these different therapeutic areas, in terms of product, in terms of research. I think that the ageing of the population and the wider access to healthcare is something which is clear for you.

So in this environment what we can do? I continue to think that Sanofi-Aventis is very well positioned for the success. We have a proven strategy. I think that this famous story of no small country, no small product is now more and more also the words of our competitors. We are a leader in innovation. If we look at our successful products on the market, we have a lot of blockbusters, even if you can, and I'm sure that you will, ask some questions of some of the products. We have a lot of blockbusters today on the market and great hopes for the future. That's what we tried to explain by the presentation of the research.

The fact that we are so well balanced between U.S., Europe and the Rest of the World is also something, in my mind, very important. It will be -- it could be more and more important for the future like the position in tomorrow's key markets.

If I look again at the next years, major launches expected, I don't go back to that. What is clear is that, if we look at '07 to '08, yes, about 10 submissions before the end of '08. That's something which could be important -- is important and could be interesting.

And if I'm looking more after to '09 to '10, it's clear that a significant number of filings expected amongst these 20 potential R&D projects. So, to conclude I think that yes, we will continue our policy. I think that we are in a leading position in many high growth therapeutic areas. Again our balanced development geographically is something interesting.

What is also interesting is, you remember this Company -- remember the position of this Company which has now merged inside Sanofi-Aventis some years ago. If you look at the figures, if you see the profitability of these companies some years ago, it's totally different from the profitability today. And the level of our profitability today in front of our turnover, you know, is one of the best of this industry.

Certainly, if you look at the fact that we pay, certainly, more taxes than our -- many of our competitors. But that is something which is important for the future, a high level of profitability. After I spoke about the blockbusters and what we have in front of us. So we continue to remain with our goal, strong, sustainable and profitable growth. Thanks very much.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

So now, we give you the floor.

QUESTIONS AND ANSWERS

Operator

Thank you. [OPERATOR INSTRUCTIONS]. We'll take our first question from Tim Anderson with Prudential Securities. Please go ahead sir.

Tim Anderson - Prudential Securities - Analyst

Thank you. I know you can't say too much on Acomplia. I have four questions on Acomplia, hopefully, they are in your comfort zone. The first is, on your Serenade trial, when will your final data from that be in your hands?

The second question is when we'll hear from you following your meeting with FDA on Acomplia, because you keep saying you can't say too much until you have that meeting. I'm wondering what the form's going to be for that. Would it be a press release or maybe your March 22 meeting in the U.S., or what exactly?

The third question is your updated thoughts on whether that drug still might go up before an FDA advisory panel?

And then the last question just relates to your news announcement last Friday, on FDA issuing a decision on weight management and on smoking cessation. You didn't mention regulatory decisions on other indications I think you filed on. Does this mean those are still under review, or that you just haven't said what FDA did on those, or that they are somehow embedded in the weight management indication?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

Okay, again one more time, we are very sorry but we don't want to comment anything, including the PI for sure. We are not discussing the [inaudible] yet with the FDA. Please, I do hope that you can understand that we just need to meet the FDA and to work with them on the dossier and that's all.

And concerning the Serenade study, we do hope to have the results of this compound by the end of this year or beginning of 2007.

Tim Anderson - Prudential Securities - Analyst

Okay, and just how about that other question about when we're going to learn more about your meeting with FDA?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

No, no. First of all, we have to meet them and we don't want to say anything about that. Please understand that our first priority is to meet them and to work on the dossier and not to communicate on that.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Tim Anderson - Prudential Securities - Analyst

No, I understand. I guess my question is, following that meeting, are we going to have to wait until the April earnings call or something like that, or what do you anticipate?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

Too early to say. We didn't meet the FDA yet.

Tim Anderson - Prudential Securities - Analyst

Okay, thank you.

Sanjay Gupta - Sanofi-Aventis - IR

We don't intend to communicate on an ongoing basis with our discussions on the FDA.

Tim Anderson - Prudential Securities - Analyst

Thank you.

Operator

We'll move on to Andy Kocen with Redburn Partners. Please go ahead sir.

Andy Kocen - Redburn Partners - Analyst

Thanks for taking the question. I've got a couple of questions. I think there are a number of ex-U.S. patents expiries on Amaryl around this sort of time. Could you comment on the magnitude of sales at risk of generic competition?

And the second one is on your associate income and the Bristol-Myers territories JV. The margin of the Bristol-Myers JV increased strongly historically, up to 2004, but it didn't -- the net profit margin didn't increase in 2005, despite 30% on the top line. Could you explain what's going on here and what we should expect for 2006 and beyond? Thanks.

Hanspeter Spek - Sanofi-Aventis - EVP Pharmaceuticals Operations

Well, I take Amaryl. As you know probably we have, in some countries already, generic competition where we have the usual picture. We work with different generics. We work with authorized generics and we usually succeed to keep about 40 to 50% of the volume sales.

In other markets the patent is off, but we don't have yet generic competition. For example, this is the case in France, where we put the same measures in place as, for example, in the U.S. And then there are other markets where the patent never has been branded or exercised like, let's say, Poland or other Eastern European markets, where the product continues very, very strongly in terms in volume and in value. So if I sum this up, I think we will be more or less able to keep the sales stable when we have bottomed the loss of patent in the U.S., which will then be in the second half of 2006.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Andy Kocen - Redburn Partners - Analyst

So, we shouldn't expect major declines in the ex-U.S. sales of Amaryl?

Hanspeter Spek - Sanofi-Aventis - EVP Pharmaceuticals Operations

No.

Andy Kocen - Redburn Partners - Analyst

Right thanks.

Operator

And now we move on to Lehman Brothers with Jo Walton. Please go ahead.

Jo Walton - Lehman Brothers - Analyst

Good afternoon. I know it's a little early to look at 2007, but I wonder if you could tell us whether you expect the launch costs that you are going to incur in 2006 to continue into 2007, and whether you could tell us a little bit about your longer term R&D plans?

I wonder if you could also talk a bit about what your objectives are in sales or, perhaps, market share terms for Plavix in Japan? With Daiichi still selling Ticlid and with their interest in [plasugrel] in the future, how significant do you think they're going to be as a marketing partner for you for Plavix?

And as you have spoken a lot about the joint venture with Merck in vaccines, I wonder if I could push you to say a little bit about the profitability of that? You have suggested that Merial profitability went up strongly in '05. Was this an investment year, perhaps, for the vaccines joint venture?

And, I know you can't tell us too much about the profitability, but over time, would we expect this to be as profitable as a typical pharmaceutical company?

Hanspeter Spek - Sanofi-Aventis - EVP Pharmaceuticals Operations

Perhaps, I pick up the launch costs issue first. It's difficult to answer Jo, it depends of course when we precisely will launch Rimonabant and, within our overall launch cost estimates, Rimonabant by far plays the most important role because dronedarone is a very, very attractive product also commercially, but it's so attractive because it will go into a very selective target group. So the launch costs of Rimonabant is by far the most important.

In general terms, I would say, if we would succeed to launch by mid-2006, just to get into a kind of scheme, the launch costs in 2007 would be about the same as in 2006. Now if we launch later, the launch costs, evidently for 2006, will be higher.

Plavix target sales, we have said earlier that we believe that Plavix, over the years, will become a Japanese blockbuster. You may remember that maximum sales of ticlopidine have been close to \$450m. This is now years ago because ticlopidine and Aventis, all other products, since many, many price decreases.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

You see from our presentation that the market, with 33%, is strongly growing and you see further that we will do more or less the same kind of lifecycle management with Plavix in the Japanese market as we have done before. Next step will be as of 2007, latest 2008, the usage in acute coronary syndrome and, of course, [inaudible]. And I believe it's fair to say that there will be some-out-of label use right away from the launch.

So, then the plasugrel issue. Look, I would not like to disclose too much about our agreements, but I just assure you that we have found adequate ways to protect ourselves. It is clear that if Daiichi would go on a launch plasugrel in Japan, we would discontinue even with a certain period of wash-out, the co-promotion of Plavix. So we take this product very serious, plasugrel. But on the other side, we hear that a launch in Japan is not very realistic before 2008 or, perhaps, even beyond.

Jean-Francois Dehecq - Sanofi-Aventis - Chairman and CEO

Okay, as far as our joint ventures with Merial, you well know that we cannot disclose the precise figures. Now we mentioned earlier that Merial has been doing very well in '05 and better than '04. As for us, the vaccine JV is cancelled.

You will remember that, in '05, we have a setback which we had to stop in the market, so you can imagine that profitability did not improve very much this year. Now as for us the future is [cancelled].

You've heard from Wayne Pisano that they expect the product launch in the years to come and I would just like to mention the others, even [Rotatech], which are going to be launched in Europe in the years to come. Thus it is fair to say that we're going to invest to prepare and launch this product and then expect a huge improvement in this European JV in the years to come.

Jo Walton - Lehman Brothers - Analyst

Can I just also ask why you're going the drug Rimonabant and not Acomplia? Is there a change in name?

Hanspeter Spek - Sanofi-Aventis - EVP Pharmaceuticals Operations

Well, it is true that we have so far no clearance for Acomplia as a trademark in the U.S. This is part of our conversations and there is a clear option that we would go with a different trade name in the U.S. than Acomplia, but there is no final decision yet.

Jo Walton - Lehman Brothers - Analyst

Thank you.

Operator

And now we move on to Graham Parry with Merrill Lynch. Please go ahead sir.

Graham Parry - Merrill Lynch - Analyst

Good afternoon. Just following up on some financial questions. Looking at cost of goods as a percentage of sales and SG&A as well in the fourth quarter with your launch costs and, obviously, the generic competition you're seeing much higher percentages. I was wondering, with the ongoing generic competition launch costs in 2006, whether this would be a good basis for us to be forecasting going forward?

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Secondly, I'll try one on Acomplia. You've said no new studies needed in weight management. Does that extend to no new data needed, in terms of additional analysis of existing studies?

And thirdly, on guidance for 2006, can you confirm whether that includes an assumption of generic Ambient in the fourth quarter? Perhaps you can give us a little bit more feel for what the actual mechanics are, and the timelines for getting the exclusivity extension on the patent. So, for instance, do you actually have to complete the pediatric studies, or do you just have to have started them?

And then finally, one question on M100907. Perhaps you could just explain a little bit more between the objective and subjective WASO and TST measures. It seems to us that the objective measures don't seem to achieve statistical significance, but are these the ones that you would be using in Phase III and which you would have to file on? Thank you.

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

Concerning the last question with the 5HG2A which is an antagonist, don't forget that we have a very small number of patients and that's only to choose the dose and this study was built up for that. We definitely believe that the right dose is 2mg and, you know, with more patients in Phase III and with more objective and subjective measurement, for sure, we'll know more about this compound.

Don't forget that we have two compounds, one which is already in Phase III with this mechanism of action, [eprivanteril], and that we validate one more time this approach with these compounds. Again, it's too early how we'll position both compounds but, in any case, we're very happy that we were able to validate this hypothesis.

Concerning Rimonabant, as you mentioned, you try, -- okay you try, that's all. We don't want comment more. Sorry again for that.

Jean-Claude Leroy - Sanofi-Aventis - SVP and CFO

Now when it comes to try to get a detailed guidance on each line item of the P&L, I'm a little bit sorry that I won't give any answer. Just I mentioned this morning that, as far as the R&D line is concerned, it is obvious to us that, because of the huge quantity of clinical trials that there is on the program, the base of development of the expenses during the last quarter of '05 will be more a reference for '06 than the entire year rate plus two that we saw.

Now, you asked the other question on the general guidance about Ambien. Again, be sure that I'm not going to give any kind of detail of the kind of hypothesis we made. Let's just say that, on the general guidance -- as a general guidance for the Company, we said that we would make plus 10% on an EPS basis and now we're not going to give all the underlying items which are included in our assumptions.

Graham Parry - Merrill Lynch - Analyst

Could you perhaps give us a feel, though, for the mechanics on pediatric exclusivity then? So do you have to have completed your studies and submitted them to FDA to get the exclusivity extension?

Michel DeWilde - Sanofi-Aventis - SVP Sanofi Pasteur, Research and Development

For the written request, as you know, we received this written request for pediatric indication by the FDA. We already started both studies, the technical one and the clinical one, and, as soon as we'll finish that we'll go and discuss with the FDA in order

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

to see whether they will be happy or not. And you know that this means that we'll have six more months' protection for Ambien itself.

Graham Parry - *Merrill Lynch - Analyst*

And you're comfortable that you would have the, I think they're eight week studies, that they would be complete in time to do that ahead of the patent expiration?

Michel DeWilde - *Sanofi-Aventis - SVP Sanofi Pasteur, Research and Development*

We believe that we'll be able to perform this clinical trial before summer.

Graham Parry - *Merrill Lynch - Analyst*

Great, thank you.

Operator

And from Citigroup, we move on to [Ahmed Roy]. Please go ahead sir.

Ahmed Roy - *Citigroup - Analyst*

Hello, yes thank you. Just a couple of questions on SR14778. Firstly, do you think the lack of the peripheral effect of 778 is down to some sort of difference that we've not characterized about the CB1 receptor, compared to other CB1 receptors in the brain?

And following on from that, how do you reconcile the GI side effects that you are getting with 778, but without the peripheral side effects -- peripheral beneficial effects I should say of 778?

And a third question just about the Stradivarius and Auditor trials. I see there to be a little bit of a difference in the dates. On your slide you suggest the Stradivarius and Auditor trials reporting data in 2010. On the clinical trials I've got it's more like 2008. I just want to make sure I understand what the correct date is. Thank you.

Gerard Le Fur - *Sanofi-Aventis - SVP, Science and Medical Affairs*

Concerning the SR compound, the CB1 receptor antagonist, you know we don't have the total explanation but keep in mind that we already demonstrated in humans and it was demonstrated in animals by people from NIH and by us in the liver and by us in the adipose tissue that, in fact, CB1 receptors are quite important for the excretion of [adipocants] in one case and for lipogenesis in the other. Meaning that, concerning Rimonabant, maybe or let's say, 50% of the effect, or quite a lot of the effect of Rimonabant might be linked to a peripheral effect.

In animals this back-up compound seems to be very efficient in all the, let's say, CNS effects linked to a blockade of CB1. Until now there is no difference between the peripheral and central CB1 receptors. But it remains bottom line that sometimes compounds are more efficient across more [BBB] or are more efficient in the adipose tissue than the other. And again, it was exactly what we got, that's why we don't have possibly the right explanation but, apparently, this compound seems to be less peripheral than Rimonabant itself.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

The difference in date concerning the presentation of Pierre Chancel and what -- where is that? It corresponds to the launch of the clinical indication. When we mentioned, for instance, that we do hope to get the results of Serenade by the end of this year, beginning of next year, that means that possibly for the patients it will be useful roughly one year after. So the difference is there. But we have no change in the clinical trial. Roughly all the lifecycle management with Rimonabant, all the clinical trials already started.

Ahmed Roy - Citigroup - Analyst

Thank you.

Operator

And from ABN Amro, we have Michael Leacock. Please go ahead sir.

Michael Leacock - ABN Amro - Analyst

Hi, I have a few questions if I may. Firstly, could you just talk a little bit more about Xaliproden, particularly in the neuro-protectant indication, and is the Xenox II study identical in protocol to the Xenox I?

Could I ask about teriflunamide and the timing there? It seems to be taking quite some time in Phase III. Could you talk through any issues there might be with your oral MS drug?

And finally, and again, as Acomplia is such an important drug, I will at least ask the question which is, you now say a planned schedule launch of H2 '06. Could you give some sort of idea of the level of confidence you have in that timing, and whether you'll be shipping into 2007?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

Concerning Xaliproden, the protocol of Xenox II is quite similar to Xenox I, meaning that the dose is 1mg and that we have a look on the neuro-protected activity of this compound versus peripheral neuropathy induced by oxaliplatin. And, for sure, we'll look up the possible, which was the case in Xenox I, lack of effect of Xaliproden on the efficacy of oxaliplatin, so quite similar.

Concerning teriflunamide, this compound, I agree with you, is in Phase III for a long time. The difficulty is that we use -- the clinical trial already started was in monotherapy versus placebo, which is not easy for to find a new patient for such a clinical trial. That's the main reason of this delay.

Hanspeter Spek - Sanofi-Aventis - EVP Pharmaceuticals Operations

Well, I understand that your question on the filing concerns Rimonabant again. So you see, we always report to our best knowledge, to our best belief. You have understood that we have a next session now in March with the agency. In knowing what is in the two letters, we conclude from our today point of view, that a launch in the second half of 2007 is the best possible opportunity which presents -- excuse me, 2006, yes, in the second half of 2006, is the most probable launch period we can estimate as from today. And I think even Gerard cannot say more than this.

Michael Leacock - ABN Amro - Analyst

Thank you very much gentlemen.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Operator

We'll move on to John Murphy with Goldman Sachs. Please go ahead sir.

John Murphy - *Goldman Sachs - Analyst*

Yes, good afternoon. I've got three questions please. Firstly, on Lovenox, can you give us any update there, in particular with relation to the citizens' petition? Have you had any response from FDA?

Second, and apologies for this. I know it was asked earlier on in the French session, but the translation wasn't clear. Can you clarify on idraparinux what your strategy is now? Are you just going to go with the biotin coupled product?

And then finally, you proposed a very strong increase in dividend for this year. I just wondered if you could make any comment on dividend outlook, at least in terms of strategy. Is it to grow it in line with earnings? Do you have a certain payout ratio targeted, for example?

Hanspeter Spek - *Sanofi-Aventis - EVP Pharmaceuticals Operations*

So, I start first with the citizens' petition. There is nothing new. The FDA has confirmed when the petition had been filed. Since, there is no other reaction to our knowledge from the FDA.

Jean-Claude Leroy - *Sanofi-Aventis - SVP and CFO*

As far as the dividend is concerned, you are right. It's fair to say that the increase in the dividend for this year will follow the increase in the EPS we just recorded. Now we're talking about a 27% increase which is not nothing, even though the yield is only 2%. Now it's not impossible that, in the future, there would be a slight increase in the payout ratio, but now we're still having 10b of indebtedness at the end of this year, so we figured out that it was a good policy, a good balance for 2006, to follow up again to do a little more than the increase in the EPS. We'll see that if we can increase a bit that dividend policy.

Gerard Le Fur - *Sanofi-Aventis - SVP, Science and Medical Affairs*

So, concerning the strategy of the launching between idraparinux and biotinylated idraparinux, frankly speaking, it's a little bit too early to say anything. Don't forget that we'll start the Phase III study with the biotinylated idraparinux second quarter this year, although in the Phase III program, the Vanguard program of idraparinux is much more advanced. So we'll see in the near future. Right now we have in mind to launch both compounds but, again, we'll see as a function of time if we change our mind.

John Murphy - *Goldman Sachs - Analyst*

Thanks very much indeed.

Operator

And now we move on to Alex Evans with Deutsche Bank.

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Alex Evans - Deutsche Bank - Analyst

Thanks for taking my call. I just -- most of my questions have been already asked and answered and I just have one remaining question relating to dronedarone. If FDA wants additional safety studies from the Athena study, I was just wondering when you could have that data ready, or whether you could have an interim look at the data or when you expect the fuller results from the Athena study to report?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

Concerning Athena, as you saw, 40% of the patients are recruited. Again, when you have only 40% it's difficult to speculate, but we believe that we'll finish, for sure, the recruitment of the patients, let's say, by far before the end of this year. And don't forget that, and too early to say, that we have an interim analysis with this compound that was accepted by the FDA and if the FDA ask for this data, again one more time we'll discuss with them. Until now we have no feedback with the FDA concerning dronedarone, so we don't know whether or not we'll need Athena or interim analysis of Athena.

Alex Evans - Deutsche Bank - Analyst

Sorry, when did you say the interim analysis would be available?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

The interim analysis will occur before the end of this year.

Alex Evans - Deutsche Bank - Analyst

Okay thank you.

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

And the full results one year after.

Alex Evans - Deutsche Bank - Analyst

Thanks very much.

Operator

And now we move on to Andrew Oh with Leerink Swann & Company. Please go ahead sir.

Andrew Oh - Leerink Swann & Company - Analyst

Yes, thanks for taking my question. I was just wondering, are there any plans to conduct registrational trials in the Type II second line setting with Rimonabant?

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi-Aventis - EVP Pharmaceuticals Operations

Could you please repeat the question?

Andrew Oh - Leerink Swann & Company - Analyst

Yes. Are there any plans to conduct registrational trials in the Type II second line or refractory settings? You have studies in the pre-diabetes and Type II naive setting, so I was curious if there are any plans to conduct trials in the second line setting? And if not, why not?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

No, as you know, we have already started a first line study and I can say, more or less and really repeat finally what the second line study -- RIO diabetes sorry, RIO diabetes was roughly a second line study [causing to] on top of a roll anti-diabetic agent.

Andrew Oh - Leerink Swann & Company - Analyst

And so why aren't you conducting a second line or second study to try and get that indication?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

Yes, we do another study in order to get first line clinical indication, and also to have the association with insulin. It's already mentioned by Pierre during his presentation.

Andrew Oh - Leerink Swann & Company - Analyst

Okay, thank you.

Operator

And now we move on to Alexandra Hauber with Bear Stearns. Please go ahead.

Alexandra Hauber - Bear Stearns - Analyst

Good afternoon. Thank you for taking my question. Sorry, I have a follow-up question on the, actually, follow-up compound to Acompli. When you mentioned that in the qualitative difference that we don't see the peripheral effects, could you be a bit more specific? I mean, do you not see any HCL increase and no glucose or [ID] increase at all, given that what we've seen with Acompli wasn't huge effects and the [inaudible] in HGA1C in that small study? Have you actually had some diabetic patients in there? I'm just wondering whether it's really, based on that small study, whether you really can make a final conclusion on the extent of the peripheral effect?

And the second question is regarding to your overview on the line extensions, that was page 102. I was just wondering what is making the cut to get on to that table and what isn't? Because, for example, we do not find a Plavix primary prevention indication filed there, but you do have filings in there for which we haven't seen data either, such as Eloxatin in pancreatic cancer?

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

No, for instance, for the line extension when you mention primary prevention, this corresponds to prevention [inaudible] patients, it's only wording, the difference. But maybe we didn't put all the line extensions because, frankly speaking, we have too many and that's why we didn't want to comment too much on that.

Again, concerning the difference between the back-up of Rimonabant and Rimonabant at the peripheral level, again, we'll see with other CB1 receptor antagonists what will happen. But again, I repeat that, in animals, Rimonabant seems to be more potent than the back-up at the peripheral level, and that the reverse is true for the central effect.

And apparently, in one study, but it's still a Phase IIb study, we got roughly similar effects on weight loss and on weight concerns versus placebo which was close to the one of Rimonabant. But again, less effect on the cardiometabolic risk factor, that's a fact. The exact explanation is possibly difficult to have right now but, again, that's why we believe since 50% of the effect of Rimonabant is in [dependence] of the decrease in body weight, it's really a strong difference between both compounds, in humans, in obese patients.

Jean-Francois Dehecq - Sanofi-Aventis - Chairman and CEO

Just one last question.

Operator

From Wall Street Journal, we have [Shaun Ballane]. Please go ahead.

Shaun Ballane - Wall Street Journal - Analyst

Yes thank you. I wonder, you mentioned that in the non-approvable letter for Rimonabant for smoking cessation that the FDA asked for new trials. Do you plan to carry out those trials and re-submit the drug for smoking cessation approval?

Gerard Le Fur - Sanofi-Aventis - SVP, Science and Medical Affairs

Again, one more time, I'm really sorry but we already mentioned to you, let us meet the FDA, let us work and discuss with the FDA. We don't to comment more on Rimonabant. We mentioned to you that in the letter we were asked to perform a clinical trial in smoking cessation, and we were not asked to perform a clinical trial in obesity. We don't want to comment more.

Shaun Ballane - Wall Street Journal - Analyst

Okay.

Jean-Francois Dehecq - Sanofi-Aventis - Chairman and CEO

Okay, so thank you very much. We have to apologize because the sound is behind us and not in front of us, so it was a little difficult for us to understand the questions but I expect that the answers were good.

So thank you very much.

FINAL TRANSCRIPT

Feb. 24. 2006 / 9:00AM, SNY - Q4 2005 Sanofi-Aventis Earnings Conference Call

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2006, Thomson Financial. All Rights Reserved.

Exhibit O

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

Event Date/Time: Mar. 22. 2006 / 1:00PM ET

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

CORPORATE PARTICIPANTS

Sanjay Gupta

Sanofi-Aventis - Head of IR

Jean-Claude Leroy

Sanofi-Aventis - CFO

Hanspeter Spek

Sanofi-Aventis - EVP, Pharmaceutical Operations

Gerard Le Fur

Sanofi-Aventis - SEVP Science and Medical Affairs

Tim Rothwell

Sanofi-Aventis - President and CEO North America

CONFERENCE CALL PARTICIPANTS

Tim Anderson

Prudential - Analyst

David Moskowitz

FBR - Analyst

Roopesh Patel

UBS - Analyst

PRESENTATION

Operator

Good day ladies and gentlemen and welcome to today's Sanofi-Aventis full-year results 2005 conference call. For your information, this conference is being recorded. At this time, I would like to turn the call over to your hosts today, Mr. Dehecq, Mr. Le Fur, Mr. Spek and Mr. Leroy, who will start the conference in a short while. Please stand by.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Sanjay Gupta, head of IR. I would just like to read the cautionary forward-looking statement before we move to the meeting and before I introduce the participants to you. So the presentation today will of course contain some forward-looking statements. These are not statements of fact or actual achievements. They're subject to considerable risk factors and I would encourage you to read the first slide because it is -- it's true as you have seen from the press release this morning that we cannot guarantee all the outcomes.

On the dais you have -- (indiscernible) so you have Mr. Dehecq, who is our Chairman. On his left is Gerard Le Fur, who is our head of R&D. Next to him, Mr. Le Fur, is Jean-Claude Leroy who is our CFO. And on the extreme right is Mr. Spek, who is head of operations worldwide.

The format of the meeting today is basically -- not on the dais but in the room are Tim Rothwell, who is our U.S. CEO. Along with him is [Saul Rayford] who is head of R&D activities in the U.S. and specifically provides us the development. And we also have Marie-Helene Laimay, who is our chief of audit, and she is very instrumental in implementing the Sarbanes-Oxley inside the Company.

The format of the meeting is a presentation for about 30, 35 minutes and then we will have a lot of time for Q & A. And I am sure you have a lot of questions relating to different matters. So I give the word to Mr. Leroy.

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

Jean-Claude Leroy - Sanofi-Aventis - CFO

Okay. Good afternoon all of you. A few words about financials of 2005 and I will begin by a few words about the P&L in 2005. And as you can see here, also a few words about the fourth quarter because it's a bit different from the full-year.

Just to give an overview, first you all know that during the first quarter of 2005, we had generic [rotation] of four products in the U.S., mainly Allegra, and that -- the picture is a bit different stars the P&L is concerned than it has been for three first quarter of the years. So that is the main reason for which you can see the (indiscernible) I go through the operating income level that -- the increase we're doing that fourth quarter was limited to 6.4% when, on a full-year basis, we reached almost 19% of growth.

If I go further, which one is it -- okay -- can you switch? Please? Which one is it? This one. Okay. If we go bottom line, the performance of that last quarter of 2005 was rather good and increased by 20% at the EPS level when the full-year was plus 25.7.

Now, there are some specifics, some selected items which we are now used to report on each quarter and also for the full-year basis which benefited to the fourth quarter and which indicate that [is] a quote, unquote normal performance of the fourth quarter was rather something around plus 10% to (indiscernible) when the full-year again comes directly at plus 25 and out of these selected item more around plus 23%.

Another figure which I guess is of interest to you is that the ratio -- about the ratio [on sales], first on the operating income. You see that the full-year was over 33% of the sales, which is an improvement by 3% over last year, definitely all the synergies which we are put in place already at the beginning -- in the second part of 2004 brought a lot to the Company in 2005. And we'll be back on this item later on.

And you can see that now on the full-year basis, we are reaching that 23% percentage out of sales level, which I guess when you compare with our peers, that is rather good during this year. So, it is -- these figures I just quote, maybe we can see that the net full-year result is 6.35 billion. And this ratio I was mentioning, the adjusted EPS for the full-year being for EUR0.74 a share.

I was mentioning the synergy area. You remember when we announced the operation, we gave a target of EUR1.6 billion on a cumulative basis had to be reached at the end of 2006. You know now that we were capable of going faster and that instead, if I may, reaching 60% by the end of 2005. We're close to 90%, so doing what we already said at the end of the first half of 2005, going fast as well in the [positive] area and in the pace, the growth of sales. And I am comparing with the full market, as well as getting some costs in the areas where they were [either] spent or obviously bringing together all of the headquarters around the world when we gathered the companies in over 80 countries.

That is to say that this story of synergies now we can set behind us. There will be some few more beginning of '06. We won't change -- we haven't changed and we won't change the full target of 1.6 billion just because we're investing a lot in R&D, we're investing a lot behind the product. We did that especially here during the fourth quarter of 2005 behind Ambien CR, for the preparation of the launch of Plavix in Japan, as well as the launch of (indiscernible) in the main countries and mainly in the U.S.

And as an information, you can see that we have reached close to 1.6 billion [OS] before tax and restructuring costs. We said in the beginning the target was 2 billion; the estimate was 2 billion. We will finish if [I'm at] operation with a little bit less than the 2 billion we mentioned earlier.

When it comes to cash flow, I think it's interesting to see on the full year basis that we were able to deliver free cash flow over 4 billion -- 4.3. Even though the figures would look like similar to the one in 2004, obviously because of the content, and I am talking mainly of a set disposal in 2004. This is a tremendous improvement from 2004 to 2005.

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

In addition to that, I have to mention that in the past Aventis was used to selling some receivables, which is a policy which we did totally stop in 2005. In other words, we had to finance close to 500 million in addition to the [rate], which is by definition included in this 2005 year. That does mean that in 2005, the real actual free cash flow we're capable of generating was 4.8 billion. And as you can see, I said is a disposal equals more or less acquisition and -- acquisition of consolidated investment. So we can see that it's something on which we can rely upon.

And this is interesting when we compare to the original \$16 billion debt -- billion euro debt, sorry, which we took when we acquired Aventis. You see the [gearing] is now rather comfortable -- 21%, not only because of the cash flow generation when I compare to 2004, but also with the evolution of the cross between U.S. dollar and the Euro, it has been a very favorable to the dollar in 2005. And therefore that does explain around half -- 50% of the improvement of the gearing at the end of 2005.

Following that evolution of the P&L and the EPS, we decided that -- the board decided to propose to the GM that we increase dividend by 26.7% at EUR1.52 a share. We can say maybe it's -- it could have been better. It is important for you to remember that it represents a 130% dividend growth over the last five years and that we have to put that in perspective with the fact that we ended the year of 2005 with close to EUR10 billion debt, 9.9 to be precise. So that we have to have some kind of an equilibrium between the financing of the Company, reimbursing the debt, and paying dividend to the shareholder -- reason for this increase of 26.7%. Thank you.

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

(multiple speakers) Yes, good afternoon. I would like to share some of those [charts] you're probably familiar with because we have presented recently [the results] of 2005, mainly product related. So in AMBIEN CR, you see that this has been of course a critical launch for us, the importance of the product in front of the end of protection for AMBIEN IR.

You see on the left side of the chart that we're doing well. We have a [switchblade] which is well superior to our two [reference] compounds, Paxil and Nexium. On the right side, perhaps even more encouraging that the launch of AMBIEN CR gave new [exigence] to the whole family of Ambien because the whole group is now [accruing] currently by approximately 15% in total prescriptions.

So we are rather content with the performance of AMBIEN to perhaps preempt a question which may arise -- have we seen yet an impact on prescriptions coming from the recent public debate? The answer is no. We have not seen such an impact, but it is, of course, totally premature. We have to see what happens in terms prescriptions during the last week and in the ongoing week, but we are at your disposal during the answer and question session.

(technical difficulty) (multiple speakers). [A piece of our] (indiscernible) launch is foreseen for 2005, especially in the U.S. (indiscernible) had been launched already as I mentioned [market] in Germany last year where we continue to do very well also in terms of newer competition coming from Novo Nordisk. We have launched the product during February and March in the United States. What we have so far is a qualitative feedback is very much encouraging and is perfectly well in line with what we have seen so far in Germany.

On the right side, you see that in fact we are aiming to the two most [constantly] growing elements of the total insulin market. As an example, you have the US market. You see that yes, in fact, (indiscernible) of 53%, [this is] a rather large volume and value is representing nearly a third of the market. And you see further that we go in through the market of rapid analogues with Apidra, which is also very strongly growing at 26%.

Next launch which is imminent in Japan is [in] Plavix. You're very well aware that evidently it took us about 7, 8 years to get the product to the market according to the specific conditions of the Japanese market. Perhaps more important, we have used this time to renegotiate our agreements with Daiichi which means (indiscernible) has merged into a new company because of [this] Sankyo.

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

And the consequence is that from this previous license agreement we are today forced [to] launch an agreement where Daiichi stays on our side, but only as a co-promotion partner, which means that in the total stream -- the financial stream of this launch goes into our (indiscernible) side. And of course we're very confident concerning the potential of this product. The predecessor (indiscernible) had maximum sales of nearly \$0.5 billion beyond -- in the very final price negotiations as of today for (indiscernible).

We are aiming for a price -- the period to the average of the European price, so something between the European and American price. And we are preparing for a launch during April, May and our other [countries] and said we will do so. We have increased our own sales force, and as mentioned before we will do this in co-promotion with Daiichi.

The product for the time being will be launched in (indiscernible) indication, but there's very intensive lifecycle management going on. Consequently, we're foreseeing the launch in a few [current symptoms] during the period 2007 and 2008. (multiple speakers) And as you see from the chart, we're going into the market which is strongly growing at 33% despite the fact that there has been no significant launch for the last ten years.

(indiscernible) -- [Murdoch] has been deposited with the American embassy and European authorities. We think it is [not] time to talk about the potential of this product. You see a first estimate for the patients' population. You see that this is a patient population which developed with the [aging] -- age pyramid in all Western societies. And you see that we estimate the market potential will significantly increase over the next years.

More specifically, projecting [those] figures on the U.S. market, you see then that we estimate that between 1999 and [2006 sees this market] just driven by the population more than triple. This is once again a market which has not been any innovation during the last -- allow me to say 20 years. The reference compound is another compound coming out of our research; amiodarone, which is a terrific product in terms of therapeutic effect, but unfortunately burdened by significant side effects in terms of organ toxicity. And what we know so far those classical amiodarone side effects are not imminent.

This dronedarone you know, I hope; that we had one trial which has been problematic because we have a higher rate of death in the dronedarone group. Nevertheless, we had been requested by the authorities to file this (indiscernible) which we have done, and discussions with the authorities are imminent.

Now, our (indiscernible) ensures that the [comparable] cover a large of your questions after. You see from the chart in a very summarizing way what we are aiming for. Yes, we have a first in class compound. It is a positioning which is totally new. It is not just weight reduction. No, it is weight reduction in front of increased cardio-metabolic risk for this lipidemia for insulin resistance and inflammation.

Target population, if you take it very large, we have a population in the U.S. of more than 100 million. In fact, this is not what we are aiming for. Many reasons, first of all because the clinical trial program is not aiming for the overall population as I just outlined. No, we're looking for those overlaps. And consequently if you look to the cream segments in the chart, we estimate we have a patient population of approximately 20 million in the U.S. and this is where we are going to.

From this chart, the take away -- the most important one is that we have proof that concerning the four major cardio-metabolic risk factors, rimonabant has a direct effect on three [instances] independent of weight reduction. And this really gives the true magnitude to this product.

Lifecycle management is vast. We have very good reference in the Company. I believe we are allowed to say that what we have done over the years with Plavix, but also this (indiscernible) name (indiscernible) too. We know how to do that. You see on the left side what has been accomplished so far. All our studies in yellow have been terminated. They are public.

And you'll see also the studies in red, and once again, also studies have been initiated which means the first patients are in. And you'll see them very simplistic terms that those studies should lead [until] 2010, 2011 to a step up extension of potential [in] indication. Which means that we anticipate that this product will follow in terms of penetration in a very typical way, a

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

cardiovascular compound. And once again I believe that Plavix is a good reference. And so in closing I think this is addition to [insurer].

Unidentified Company Representative

Hello everybody. So I will briefly summarize some of the results we got, the last 12 months in R&D. So, as you can see here, we have 129 compounds in development, but maybe what is quite important is that the development of the late stage compound is accelerated last year. We have 55 public in Phase II and III. We had 48 compounds one year ago of -- in Phase II to and Phase III. So it's very encouraging.

And briefly I will start with the cardiovascular area. As you know, we work a lot on antiarrhythmic agents, on PAD, hypertension, CHF and angina. As Hanspeter mentioned to you, dronedarone we have an action date very soon. And (indiscernible) was already started a couple of months ago [and with] more than 1500 patients on roll in this clinical trial.

Moreover, we have a compound which is currently and Phase II-b which opposite -- which has the same profile than dronedarone, but this compound is administered once a day. And we finished the recruitment of these patients in this trial. Two compounds enter Phase II-b, one in hypertension and one in PAD.

And finally, you all know that we presented at the last [SEC] gene therapy which was -- which gave positive results in patients with ischemic (indiscernible) and that we got very interesting results on amputation and the train on [deaf]. Meaning that we start certainly a Phase III study with this gene therapy before the end of this year.

A few words about thrombosis; I will focus a little bit on so-called backup of rimonabant because we strongly believe that it's a new innovation. You are all aware of what happened with Plavix and Lovenox here. But this compound which is the [bio-stimulated] idraparinux, is in fact linked to the classical problem that we have with anti-thrombotic agents. All of these agents have the same side effects; that is to say bleeding.

In other words, everybody is looking for a true -- a genuine antidote, and it's even certainly more important for a compound that was administered once a week such as idraparinux. So we have the idea to use a [book] which is biotin that is linked to idraparinux through a spacer. And the antidote is avidine -- because the affinity of avidine for biotin is very, very high.

And we have plenty of results in animal and even with presented [cure] results in human showing that first of all, the biotin [related] idraparinux has the same pharmacokinetic profile that idraparinux itself in human. And secondly, it was possible to totally -- roughly totally 90 payment decrease of [circulating] so-called [anti-tenant] activity when we inject a rather high dose of this compound and with -- we after administer avidine.

In other words, because of that, we will [alone] to perform like [the bridging] development we worked with the idraparinux and who are currently starting Phase III study with this compound with really, we believe, a totally new concept for anti-thrombotic agents (indiscernible) that will allow to have a true and genuine antidote as needed.

CNS, as you know, is an area where we work a lot. This is true for both psychiatry and neurology and we have quite a lot of compound in -- in late stage and even quite a lot of even first in class compound in late stage, and also at the pre-clinical level or in Phase I. You all know that we received a recent request concerning zolpidem from the FDA. One more time I will repeat that.

We have six compounds in Phase III. We saw development of one compound in Phase II-b and got one other positive result with a 5HT2 receptor antagonist in sleep disorders. This compound which is chemically unrelated to (indiscernible) has the same profile and the same target. Such compounds are interesting for the maintenance of sleep and for the quality of sleep. They're not [sleeping user]. The increase the slow wave sleep, which is the restorative sleep. And again, we got very good --

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

with a very good [CST] profile, a very good activity of this compound which confirmed we initially got with (indiscernible) which is currently in Phase III for this clinical indication.

A few words about oncology. You know that it is one of the strengths of the Company and that we have four compounds in Phase III, (indiscernible) but I just would like to mainly talk about FGF TRAP. You all know that its target was validated by compound like Avastin, and that we got very, very interesting and more than encouraging results with this compound in Phase I. We do not presently [figure] for sure they are open results.

But you know even for safety, not too many cardiovascular side effects. And officially I would say more or less unexpected good results in very (indiscernible) patients. You all know that when we started in Phase I with anti-cancer agents, it is very resistant patients. So that is a compound that we could have [locked] with our friend from [Rogenerone]. And we are very, very happy of such collaboration, and we focus a lot and we can speed up as much as we can the development of FGF TRAP in association with our friend from Rogenerone.

A few words about metabolic disorders. You know that we mainly work on diabetes, (indiscernible) and obesity. You know everything concerning rimonabant. I can just add that we are currently working with the FDA concerning rimonabant, but I'm sorry to say that but you're pretty sure of what I said that will not comment anymore about rimonabant.

We have -- as I mentioned to you that we work a lot on diabetes, started a Phase II-b study with (indiscernible) Q1 [antagonist] but maybe what is a little bit striking in metabolic disorders is that we got good results in Phase II-b with a backup of rimonabant. To my knowledge this is the first time that somebody presents a Phase II-b study in obese patients apart from rimonabant itself. More or less, even if the protocol is not similar, even if it's only an historical comparison, we got roughly the same effect of this compound as rimonabant on body weight and same effect on weight circumference.

However, we got a very remarkable difference opposite to rimonabant. Roughly this compound has a low effect on the metabolic risk factor such as [SGL] which was increased by rimonabant; such as triglyceride which was decreased by rimonabant; and no effect on [HDA1C] which was decreased by rimonabant. So it's a backup, validates the (indiscernible) but with some difference. In other words, this compound there seems to be less peripheral than rimonabant.

In conclusion, I just would like to present to you the calendar of planned submissions. We have still at the end of 2008, roughly 14 new chemical [NTD] that we can file and 7 vaccines. Again, more time, we are not naive enough to believe that everything will be positive, but even if we apply an attrition rate of let's say 50%, so this means that possibly we'll have 10 filing of new chemical [entity] of new vaccines by the end of 2008. And it's only on vaccines and new chemical entity because we didn't include in that the line extension. So for all of these reasons, we are very optimistic about the future of the Company. Thank you.

Unidentified Company Representative

So just to make a short conclusion of what (multiple speakers) you see that -- to say that Sanofi-Aventis is now a successful integration I think that everybody knows where we are. It is interesting to speak about our objectives because if we look at what we have in mind for the next years, it's quite the same.

Remember that the beginning of '04, when we started the [fight] with Aventis, we decided that we need a strong growth, a sustainable growth and profitable growth. I think that if we look at the first 18 months, we took the keys of the Company at the end of August '04. If you look at that, yes, the sales Hanspeter Spek showed you the figures, 9.3 in spite of the story of [adding] (indiscernible) in the last quarter. It's a growth which is above all the pharma market in all the regions around the world.

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

We have done a fantastic job investing, restarting the vaccines business which was around 4, 5% per year during the last years. And we put that at 25% of growth last year and you know the success -- a successful launch of AMBIEN CR and three vaccines in the [year]. (technical difficulty)

It's interesting to have strong growth but we have to continue to have a strong growth, and for that, it's clear that the [operation] of the R&D pipeline are going -- today 55 products in Phase II and III. It was 48 in March last year. So I think the big (indiscernible) and very good progress.

Again, I repeat also something that I'm always saying around the world. It is easier to make a [recitation of me-too] products that innovative [drugs in spite of that]. I think that we will continue in the R&D of Sanofi-Aventis [who] builds new innovative drugs because I think that the future of this industry can be for the next years in the building of me-too product, but really a new innovative drug. So even if it's more difficult, we will continue this policy, [so] the policy of the last 15 years will continue.

Okay. You need -- we need good products, but that at the same moment, we have to put the sales force at the right place. And Hanspeter could give you some information if you want to understand what you're doing in new countries like China, like Brazil and so forth.

At the same moment, it is important to control the system, and to control the systems we have -- we need -- we have in mind that it's necessary for a very strong supply chain, another reason why we have a strong position in chemistry for pharma and in all the manufacturing. But during the last 18 months, what we did is a strong increase of the investment in vaccines [position], capacity, and especially in influenza. And I'm sure that you know in this country, especially, what we're doing for -- to prevent if it's necessary, for example, avian flu. Excuse me.

(indiscernible) (multiple speakers) After that, [you especially] -- but it is necessary. You ask us to have a profitable growth. I think that to put a 26% [on] growth last year of the profit per share is something interesting. But what is interesting is after 18% the year before.

So the second point, and Jean-Claude told you that we are at 90% of the cumulative synergies that we put at 1.6. So I think it's finished and that is behind us now, and we have to push the story of profit and not taking a sort of division between what is coming from synergy and what is coming from the development. I think that after 18 months you have [adjusted] to look at what is the story today and not go back to two years before.

The question of the debt also is something interesting because I remember that at the moment we build this story on Aventis, some people say that they are -- they will increase the (indiscernible) their debt. We say that it was -- it will be paid in five years. I am sure that it will be in less than five years.

What is interesting now is to give you -- some idea of what we have in mind for '06, '10. First, my first slide is in to -- I'm always [looking] that the pharma industry is a [disaster] more and more difficult than some, so what is the industry? What is the markets which within such an enormous potential despite (indiscernible) and [we're not] okay.

But a look at all of the needs in many of the [particulars] we have (indiscernible) some of them because that (indiscernible) particular areas in which we are. But it's incredible what [are the needs] after you have the aging of the population. And again, it's not very beautiful to push with good cardiovascular product the aging of the population if it's to add -- to be in a car, in a wheelchair or (indiscernible) and so forth. We need to make a fantastic progress in this way in oncology (inaudible) [one].

The last point is something which in my mind is for a long time very, very important. I think that if this industry would want to continue to grow, we have to address the equation -- the big question of why the access to [LSCAN]. But the only way to protect the -- our intellectual property and I think that we have a lot of things to do in this way. In making that, we could decrease dramatically also our business.

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

So we are very optimistic in the pharma industry even if all will change in the next future -- the next year, it's clear that today is not what is five years ago. And especially in this country, I remember the story when it was so easy to make 15, 20% of growth with the market growing at 15% per year. I think that this situation is totally finished for the future.

But we know that for years and years, for 30 years in Europe the fact that we have to decrease the prices step by step each year and not increasing any products, so it's not something -- it is something which is totally new for us.

What we have in mind, we think that Sanofi is very well positioned for this success for the future. Because of the strategy, yes, the strong growth, the sustainable growth and the profitable growth, even if each will change in the next years, I think that if we keep the same target, we will be -- continue to be at the top.

When we put that we are a leader in innovation, yes, I think -- I agree and suddenly you ask questions about oh yes, but this blockbuster will be out of patent in one or two years or three years. You know what's impressed me is that when you have nine blockbusters, yes we will lose in the next five years more than the people who have only two blockbusters which has only the chance to lose one, but I prefer to have nine -- better than to have two.

And if you look at the story of this industry and you put -- (indiscernible) a different [lineup] I'm sure you made that better than me, it's very impressive to see what will be the future. I don't go back to the results of the research. Gerard will so quickly give you some information on what is clearly a very beautiful portfolio.

Something that is interesting for this Company also is that you know, some years ago, it was not so good to be very strongly involved in Europe. Today, to be at 40% in the States, 40% in Europe, 20% in the rest of the world, with the strong growth in the rest of the world, I think that it's a very good equilibrium, which is one also of the strengths of this Company. And the experience of how to manage countries with very strong degrees of price with very strong difficulties to obtain the price is something that we have in mind and we have.

In Europe, you know we are always discussing with 25 different governments, discussing the [clear registration when we have] the EMEA with a [sort of] question of the price. For the regulation of the end of the year of each Social Security system, we have 25 negotiations per year. So yes, I think that the European company is well positioned for the future if the future will continue to be as (indiscernible) as it is today.

So just '06, '10, yes a great opportunity for Sanofi or even (indiscernible) Plavix in Japan (indiscernible) we spoke about that. I [could just] about 10 submissions before the end of 2008, because [at that] -- quite true that we will have around 10, but for '09, '10, I would suggest that significant number of filing expected among 20 potential projects that [push]. Gerard.

I don't know inside that how many real fantastic new innovative drugs. There are [somewhat]. If I look at the portfolio for my competitors, I don't see all the big innovative drug is the same for them. I continue to think that the portfolio of Sanofi is one of the best, so no change in the future. No change in the managing and the management of this Company where we'll try to continue this policy having clearly in mind that the world in the next five years, we're not the same the world in the [mind] of this world is not the same as the mind of the last five years. But we continue to be very confident in our future.

Thanks very much and I think that we give you the floor now to answer your questions.

QUESTIONS AND ANSWERS

Tim Anderson - *Prudential - Analyst*

Thank you. Tim Anderson at Prudential. Two questions. Maybe one for Gerard. I know you said you are not going to give an update on the Acomplya yet. But you had the meeting with the FDA I'm just wondering what the form for the next update is

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

going to be, is it an earnings call most likely? Or at what point in the future -- are we looking at weeks, months, or quarters, something like that?

Gerard Le Fur - Sanofi-Aventis - SEVP Science and Medical Affairs

I'm really sorry. As I mentioned to you, we will not comment anymore on rimonabant and what we are currently doing with the FDA. Sorry for this.

Unidentified Company Representative

I'm sorry. I will repeat. I'm really sorry, but I'm pretty sure that you can understand that will not comment anymore on rimonabant and what we are currently doing with the FDA. Sorry for that.

Tim Anderson - Prudential - Analyst

One other question if I can, a broader question, not Acomplia-related, but M&A has been an important part of Sanofi's legacy to kind of get where you are today. So looking forward, I'm wondering how M&A fits into your framework for the future. Do you see value in getting significantly larger such that you would consider major acquisitions? Are you looking more at midsize targets kind of like Pfizer in Merck say they are looking? Or should we assume you're content where you are today?

Unidentified Company Representative

I think again that everyone is looking if something that's possible in this way. I think that the best way is to see (indiscernible) already to make something to give you the information, that I think that yes, M&A could be something. But it's not only a question of I need to be here, a beautiful Company with very huge products, fantastic, very profitable and with a strong portfolio. As soon as I have said that, you don't find the company.

So I think that step-by-step, this Company continues to make middle size acquisitions because of that, so day to day the business. And to think it's something more important in M&A, even if we are, I think that I never say anything on that going 30 years. But during 30 years we've done a lot of things.

David Moskowitz - FBR - Analyst

Thanks very much. David Moskowitz, FBR. Can you talk a little bit about the Apidra launch? You mentioned the rapid acting insulin market is growing at 26%. Is it your intention to continue to just further the growth in that market or is -- are you targeting some of the entrenched competitors, specifically Lilly's Humalog? And also, could you talk about that launch in the context of the potential upcoming launch of inhaled insulin? Thanks.

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

So perhaps I make a comment on a worldwide level and then Tim will comment on the situation in the U.S. We're planning to launch in all markets during 2006, 2007 Apidra. There are two factors we look to. One is where are we with Lantus? We have to be a little bit careful not to distract focus on Lantus, which definitely has by far the largest growth and volume potential. And the second one is of course of availability of devices [pens].

But the product is more or less registered all over the world and we will from a very technical point of view continue to launch in the European community 2006 (indiscernible) and 2007 in the rest of the world and (indiscernible) on the U.S.

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

Tim Rothwell - Sanofi-Aventis - President and CEO North America

Can you hear me okay? So with respect to the U.S. insulin market, obviously as you correctly stated, the market is growing well. Lantus is doing very well. The issue for us has always been in the U.S. the lack of a short acting agent. So with the introduction of Apidra, which is certainly complementary from our perspective to Lantus, we expect to be able to continue to help grow that market, and hopefully take some market share away from some of the competitors.

Keeping in mind that we only launched two or three weeks ago, so we don't have much in the way of information except to say that after two weeks, we are slightly ahead of NovoLog at the same time. So far so good, but it's really a growth strategy around both agents.

Unidentified Company Representative

On inhalable, yes, we believe that inhalable is an interesting alternative to parental insulin. Nonetheless, we are convinced that inhalable will never replace injectable. We have (indiscernible) and of course (indiscernible) to Pfizer, the agreement gives us after a certain -- let's call it rush hour time, all flexibility (technical difficulty) the inhalable market segments. There are a number of opportunities outside the insulin market and we are studying all of them.

Unidentified Audience Member

Two questions please. I noted at the [ACC] -- or actually, I didn't note any presence of (indiscernible) which I find is a bit unusual [especially] before the action date. There's no presentation, no abstract, no Company-sponsored symposium. Should we infer from that that the FDA has already given you a signal that you will need (indiscernible) approval? The second question is on the 10 submissions that you highlighted until 2010. Of course you know, we're going to all sit here and [counting] them. Is this just going to be NCEs or are you going to include major line extensions into that?

Unidentified Company Representative

Concerning dronedarone, I will remind you that we presented all of the results in previous congress, so there was no reason for us to repeat what was well-known. The two positive studies (indiscernible) with a very nice safety profile. And what you know with Andromeda that unfortunately in patients with CHF we got some problem which lead us to stop the -- this clinical trial.

So there was no news, no reason to present anything. The only new thing is what you know concerning [Athena] that we already started this new trial and that we are recruiting very well the patients. And until now the [DSMB] didn't mentioned anything to us. That is to say that it's going well.

Unidentified Company Representative

Other submissions? (multiple speakers)

Sanjay Gupta - Sanofi-Aventis - Head of IR

The line extensions are on slide 102 in the book.

Unidentified Company Representative

No, the 10 submissions until 2008.

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

Unidentified Company Representative

(multiple speakers) 10 submissions are all [NCIs].

Unidentified Company Representative

Yes, yes, we have -- I repeat, you can (indiscernible) with 14 potentially to the end of 2008 plus 7 vaccines we added on the book. And I said 10 because I wanted to add -- [maturation] ration of 50%, which is rather classical in our business when you add (indiscernible) in Phase II-b or III. I could have said 20 new chemical entities, but it was only a new chemical entity plus vaccine and nothing to do on line extensions.

Roopesh Patel - UBS - Analyst

Roopesh Patel from UBS. Regarding Plavix and the CHARISMA trial, there was some encouraging data on the secondary end point with regard to Lantus therapy. Do you believe that you need to have this data on the label in order to be able to take advantage of that in the marketplace? And when do you expect this data to get onto the label if at all?

Tim Rothwell - Sanofi-Aventis - President and CEO North America

First of all, with respect to CHARISMA, I don't think we expect any label changes to the Plavix label. That is the first point I would make. Secondly, as you know, the study -- the length of therapy in the study was approximately 28 months. One of the challenges that we have in the United States is that the average length of therapy for a Plavix patient is about 150 to 160 days, as contrasted to Europe where it's about 250 days. So we believe that this data will help us to convince physicians to keep patients on Plavix longer.

Keep in mind that just a one or two day increase is substantial in terms of revenues, so we will certainly use the study to try and increase the length therapy on Plavix as it [is] today.

Unidentified Audience Member

Could do speak to Medicare Part D and the impact you're seeing on your portfolio of products?

Tim Rothwell - Sanofi-Aventis - President and CEO North America

As you know, first of all, the key to success with Medicare Part D is enrollment. The government estimated that enrollment would be in the neighborhood of some 27 million additional -- maybe even up to 35. The reality is that today -- and the date for completing enrollment is May 15th. As you know, it's really about 16, 17 million as opposed to what we had anticipated ourselves at 25, 26 and what the government anticipated as well. Enrollment is running at about 250,000 a week at the current time. So we are falling short in terms of enrollees. That is the first point I would make.

The second point is that there are really three products in our portfolio that would benefit the most -- Plavix been one, Lantus being a second, Actonel being a third. We haven't seen any, if you will, improvement or increase in sales on Lantus or Actonel. We have seen some increase in Plavix, but we don't know whether that's a function of induced demand coming from the dual eligibles converting over or whether or not it's our own promotional efforts. I suspect it's a little bit of both.

So it's really -- I think probably the best way to characterize it is as a kind of delayed response, although certainly Plavix has the greatest to gain within our current portfolio, assuming enrollment starts to increase more dramatically. I heard the other day

FINAL TRANSCRIPT

Mar. 22. 2006 / 1:00PM, SNY - Sanofi-Aventis New York Analyst Meeting & Conference Call

that the government is contemplating extending the enrollment period. I don't know whether in fact that will occur, but if it does, that would be helpful for everybody.

Unidentified Company Representative

Okay, so thank you if you have no more questions. Thanks very much.

Operator

Ladies and gentlemen, this is completing today's conference. Thank you for your participation. You may now disconnect. Have a good evening.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2006, Thomson Financial. All Rights Reserved.

Exhibit P



sanofi aventis

Because health matters

ACOMPLIA® (rimonabant) RECOMMENDED FOR APPROVAL IN THE EUROPEAN UNION

Paris, France, April 28, 2006 – Sanofi-aventis announced today that the Committee for Medicinal Products for Human Use (CHMP) of the European Medicines Agency (EMA) has adopted a positive opinion recommending to grant marketing authorisation in the European Union for ACOMPLIA® (rimonabant 20mg) for the following indication: “As an adjunct to diet and exercise for the treatment of obese patients ($\text{BMI} \geq 30\text{kg/m}^2$), or overweight patients ($\text{BMI} > 27\text{ kg/m}^2$) with associated risk factors, such as type 2 diabetes or dyslipidemia (see section 5.1).” Section 5.1 of the Summary of Product Characteristics is the section of the labelling where detailed clinical study results supporting the indication are described. Importantly, statements in this section stipulate that half of the observed improvements in HbA1c, HDL cholesterol and triglycerides were beyond that expected from weight loss alone.

ACOMPLIA®, a first-in-class selective CB_1 blocker, has been discovered and developed by sanofi-aventis.

The CHMP, comprised of regulators from all European Union countries, gave its positive opinion following a timely one-year review of the ACOMPLIA® application. The recommendation to grant marketing authorization was based on the review of comprehensive efficacy and safety data, including data from the RIO clinical trial program which involved more than 6,600 patients worldwide, studied for up to two years, where it has been demonstrated that rimonabant 20mg/day significantly improves weight and waist circumference, HbA1c, HDL cholesterol and triglycerides.

“Obesity levels in the European Union have risen significantly in the past decade in the adult population, and this represents a serious public health concern. Specifically, those with abdominal obesity are at the greatest risk of developing type 2 diabetes and heart disease, due to the link between abdominal obesity and other risk factors^{1,2}” said Luc Van Gaal, M.D., Professor of Diabetology, Metabolism and Clinical Nutrition, Antwerp University Hospital, Belgium and Principal Investigator of the RIO Europe trial. *“ACOMPLIA® is an innovative, first-in-class treatment which will offer physicians a new approach to managing multiple cardiometabolic risk factors in patients with abdominal obesity who have other conditions such as type 2 diabetes, or unhealthy lipids. We should only use this drug in such patients where there is a real medical need, and not in people who may seek to use it for cosmetic reasons.”*

Following completion of the phase III program for rimonabant, sanofi-aventis has embarked on the next chapter in the clinical development of ACOMPLIA®. An extensive program, consisting of a large number of studies including more than 22,000 patients has been designed to further investigate the impact of rimonabant on cardiometabolic disease.³

The European Commission usually delivers a European marketing authorization subsequent to a positive CHMP opinion within two to three months. Following European marketing authorization,

ress release



ACOMPLIA® will be available in European Union countries for prescription as a 20mg tablet to be taken once daily. First launches are anticipated during the second half of 2006.

The CHMP has not adopted a positive opinion for ACOMPLIA® in smoking cessation.

About ACOMPLIA®

ACOMPLIA® acts by selectively blocking CB₁ receptors found in the brain and in peripheral organs important in glucose and lipid (or fat) metabolism, including adipose tissue, the liver, gastrointestinal tract and muscle.⁴ CB₁ receptor blockade with ACOMPLIA® acts to decrease the overactivity of the endocannabinoid system (EC system).^{5,6} The EC system is a recently characterised physiological system that includes receptors such as the CB₁ receptor and it has been shown to play an important role in regulating body weight and in controlling energy balance, as well as glucose and lipid (or fat) metabolism.

About sanofi-aventis

Sanofi-aventis is the world's third largest pharmaceutical company, ranking number one in Europe. Backed by a world-class R&D organisation, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine and vaccines. Sanofi-aventis is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward-Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expect," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

Media contact:

Jean-Marc Podvin: +33 (0)1 53 77 42 23

Nazira Amra +33 (0) 6 30 32 63 15

press release



References

¹ http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/documents/iotf_en.pdf International Obesity Taskforce EU Platform Briefing Paper, March 2005. Last accessed April 26, 2006.

² Ford ES, et al. Trends In Waist Circumference Among U.S. Adults. Obesity Research. 2003;11(10):1229.

³ Clinical Trials.gov. U.S. National Institutes of Health. Available at: <http://www.clinicaltrials.gov/ct/action/GetStudy.jsessionid=4945956123EB403C45A617F376D721EF>. Last accessed April 19, 2006.

⁴ Pagotto U, Pasquali R. Fighting obesity and associated risk factors by antagonising cannabinoid type 1 receptors. Lancet. 2005; 365: 1363-64.

⁵ Van Gaal LF, Rissanen, AM, Scheen AJ, Ziegler O, Rössner S for the RIO-Europe Study Group. Effects of the cannabinoid-1 receptor blocker rimonabant on weight reduction and cardiovascular risk factors in overweight patients: 1-year experience from the RIO-Europe study. Lancet. 2005; 365: 1389-97.

⁶ Marzo V, et al. Leptin-regulated endocannabinoids are involved in maintaining food intake. Nature. 2001;410:822-825.

ress release



Exhibit Q

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Event Date/Time: May. 05. 2006 / 2:00AM ET

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

CORPORATE PARTICIPANTS

Sanjay Gupta

Sanofi-Aventis - Head of IR

Hanspeter Spek

Sanofi-Aventis - Head of Operations

Jean-Claude Leroy

Sanofi-Aventis - CFO

CONFERENCE CALL PARTICIPANTS

Tim Anderson

Prudential Securities - Analyst

Philippe Lanone

Ixis Securities - Analyst

Graham Parry

Merrill Lynch - Analyst

Jerome Berton

Aurel Leven - Analyst

Sebastien Berthon

Exane BNP - Analyst

John Murphy

Goldman Sachs - Analyst

Alexandra Hauber

Bear Stearns - Analyst

Paul Mann

Deutsche Bank - Analyst

Jo Walton

Lehman Brothers - Analyst

Michael Luchton

HSBC - Analyst

Kiyoshi Ando

Nikkei - Analyst

Eileen Robert

La Tribune - Media

Michael Leacock

ABN Amro - Analyst

PRESENTATION

Operator

Good morning, ladies and gentlemen, and welcome to today's Sanofi-Aventis 2006 first quarter sales and results conference call. For your information, this conference is being recorded. At this time, I'd like to turn the call over to your host, Mr. Sanjay Gupta, Head of Investor Relations. Please go ahead, sir.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Sanjay Gupta - Sanofi-Aventis - Head of IR

Good morning and many thanks for joining us for Sanofi-Aventis first quarter 2006 earnings call. I'm Sanjay Gupta, Head of Investor Relations. I'm joined by Mr. Hanspeter Spek, Head of Operations, and Mr. Jean-Claude Leroy, our Chief Financial Officer.

During this conference call, we may make projections and forward-looking statements that are based on management's current expectations, but actual results may differ materially due to various factors. For additional information about the factors that affect our business, kindly refer to our forward-looking statements and our 20-F.

The format of today's call will be a short presentation followed by a Q&A session. Mr. Spek will now comment on the business during quarter one. Hanspeter?

Hanspeter Spek - Sanofi-Aventis - Head of Operations

Yes, thank you, Sanjay. Good morning, everybody out there. We are glad that you have decided to share the early morning with us to look at our first quarter results of 2006.

Now, those results are perhaps not as obvious as in previous years, when we used to report two-digit sales growth, but, as you probably know, there are some or one major segment, let's say, which makes, on first glance at least, our sales performance a little bit look more decent than in past years. So if you agree, I propose that we go into the slide set and start on page number three, where you see the growth for the first quarter.

And evidently, you see a growth of total pharma sales of 3.3%, which is driven by a growth of 7.6% for the leading 15 products and a minus 4% growth for the base business. Much more impressive is the performance of our vaccines business, which is growing by nearly 31%, which then gives us an overall growth rate of 4.9% on a comparable basis.

In the geographic split, it becomes already evident where the technical problem is being situated, in the United States. Evidently, it's there where we have lost patent protection for four products during the last four months in 2006 -- excuse me, in 2005. So consequently we have no growth to be reported on a comparable basis, once again, for our United States business.

In contrary, Europe still growing reasonably well, with 5.3%. And rest of the world, which, in our last presentation, is a declared focus for our future growth, is growing strongly with more than 13%, giving for our total developed sales then a growth rate of 6.8%.

Now, if we turn to slide number four, you see in very simple terms what the generic impact on our overall business and on our U.S. business is if we exclude the sales of those products which have lost the patent protection during the last four months. And I repeat again it was Allegra, Amaryl, Arava and the licensed in DDAVP products. You see then that we would have, on a theoretical basis, a 10.4% growth in our overall sales and, focusing just on the United States, a growth of 16.1% for the U.S. business.

Now, I may add here that, if you would compare those growth rates with the growth rates we have reported for the fourth quarter 2005, you would or you will see a perfect continuity in terms of performance. There is no change to be reported also as compared with the fourth quarter of 2005.

More focus then on the vaccines business on slide number five. So 31%, which means even an acceleration of our growth as reported for 2005. How is it being composed? Yes, of course, there is an important flu business growing by about 31%, which means the same growth as the overall activity, but you see that all other segments are growing very, very strongly. Meningitis/pneumonia is driven by Menactra, largely, growing by far more than 100%. The boosters are growing by 11%, polio and pertussis by 21% [sic - see presentation] and the travel and endemic vaccines by even 81%. So the performance is excellent.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

The vaccine business is becoming more and more a very important part of our overall growth of our annual incremental sales and it is very much in line with our expectations. You will remember our continued communications that we believe that the vaccines business will do extremely well over the even years to come.

Now then, on page six, we go back to the pharmaceutical business. On first glance, you once again see where the limiting factors for our overall growth are. Evidently, it is Allegra and Amaryl, which have lost half or a quarter of their sales as compared to the first quarter 2005. For most of the other products, you see a very nice, even impressive, two-digit growth rate and an overall growth rate for the top 15 of 7.6%, or, corrected by the generic impacts, by 15%. And once again, also, this growth rate is very nicely in line with what we could report for the total year 2005.

A little bit more focus, then, on the major products - Ambien on page seven. Ambien and its class has been in a certain focus of public debate. We have commented on the issues. We have even started a specific advertising campaign in the United States. We can confirm today that this negative publicity has equally affected the total class. On one side, this is regretful, and on the other side it is understandable, because, yes, it is true that those side effects which have been reported anecdotally are true for the whole class.

Nevertheless, what you then see as a positive - there is a very positive on the right side of the chart - is the fact that Ambien came back to a very impressive two-digit growth rate in total prescriptions in the United States. We saw a certain dip coming from the press publications, but meanwhile in the latest weeklies we see that Ambien, Ambien CR as a whole family but also see the total class, has been growing already back to previous growth.

Conversion, we always have said that our major key performance indicator as a reference is the switch rate of Nexium. And as you see on the lower right side of the chart, we are slightly ahead of Nexium in terms of conversions, which means we are also satisfied with what is happening in exchanging Ambien IR by Ambien CR.

Now, Plavix; major product, of course, of the Group. Also there very good news. We have reported a slight dissatisfaction with the performance in 2005 in the U.S. We had announced a number of measures, mainly reaccelerating our investments in DTC and a strategic shift of our promotional activities more into hospitals, and as you see the, product is reacting very nicely to this. We are back on a growth pattern which is very reasonable in terms of prescription growth, resulting in an overall increase of sales for this product of nearly 20% during the first quarter. And you see that this growth is largely coming from the U.S., with plus 27%.

There are other opportunities for Plavix ahead, as you may see on page number nine. We have just last week actively started promotion of Plavix with our co-promotion partner Sankyo-Daiichi in Japan. I may report that we have obtained a reimbursed price in Japan which is superior to the European average price, so also from the economic side this launch is very promising. But it is clear that, with the delay in launch as compared to the U.S. and Europe, there are also very high expectations from the medical and clinical side towards this product. And we are very confident to have a very reasonable and relatively rapid success in Japan with this product.

Still imminent, the review of an expanded labeling coming from the ST elevated myocardial infarction. As you know, we are under priority review with the FDA and also under review with the EMEA, and we expect to hear within relatively soon how those agencies judge on the file.

Then, Lovenox. Yes, of course, you have heard or read about the court decision on Lovenox concerning our appeal. We understand this as a very positive signal. Nevertheless, it's evident we have to go back now to the first instance, but, yes, we take this as a positive decision and we are glad about it, but of course the battle continues.

Meanwhile, the product is doing very, very well, especially if you consider the volume of this product. You see on the right side of the chart number 10 that we have evidently invested into the right patient segment, which is medical patients, especially in

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

the U.S. And then, overall, a growth rate of 28% to worldwide sales of about 620m, once again largely driven by the United States, but not only. You see also that the product now is starting really to become significant in the rest of the world segment.

We feel that the product, as illustrated on page number 11, has still a bright and sunny future ahead. It is evident that many, many patients who should receive heparinization don't do so and this is true for all parts of the world. The figures we give here, for example, for the United States - 46% of patients treated are still being used with unfractionated heparin. We have published very recently very, very favorable data for Lovenox in comparison to unfractionated heparin.

And as you see from this chart, besides, it's a large, large market open with 28m of patients who don't receive any kind of protection. And so consequently, yes, we remain extremely positive about the future growth of this product.

Another major growth driver - and that's not at all surprising, because, as you see on page number 12, it is more than a linear growth even - is Lantus, the number one branded insulin worldwide, which is growing at 42% during the first quarter. Once again, you see that this is a growth coming from all parts of the world. And as you see on the top of the bars on the left side, our sales outside the United States and Europe are growing now by nearly 100%, indicating clearly that diabetes becomes epidemic now also in the southern hemisphere.

Lantus is, nevertheless, in a competitive environment, as you see from page number three. As nearly usual, we have benchmarked our performance against Levemir and I think that the three graphs for France, Spain and Germany speak for themselves. Also, if Levemir has a certain development, which is the case in Spain, you see that Lantus reacts immediately to it and by far remains the leading compound, due to its unique profile, mainly headlined by a true 24 hour peakless profile.

Now, Taxotere. Taxotere is a product which continues to cause some concern in the United States. We still have reason not to be entirely content, despite the fact that, then, on a worldwide basis, the product is growing by more than 10, 11%. But if we look into the U.S., we still see standstill and, outside the U.S., we see then a growth of 17% or in the rest of the world part even by 25%.

This is, for us, continued encouragement not to give [up IMC] U.S. We have made major organizational changes in the United States, where, besides a technical reimbursement issue, our main problem is that we have lost positions in metastatic breast cancer. And despite good growth in the other indications, we are not able to compensate this, so consequently metastatic breast cancer is our major field of activity during the months to come in the United States.

Then, on page 15, finally, Eloxatin. Very healthy growth, 15%, as you easily can see from the chart. We have a number of interesting opportunities ahead. As you see, we are presenting new data in pancreatic cancer and in gastric cancer during the ASCO convention. You see further that we plan for stage two colon cancer to submit metaanalysis from various trials.

We had launched, during 2005, step by step, in meanwhile nearly all markets a new aqueous formulation. This formulation does extremely well. As you see, we have already 100% substituted the previous formulation, which obliges the nurses and the hospital personnel to make manipulations. And you see also that also in the United States we are approaching a 100% substitution by this new form, which, of course, contributes to the overall performance of the product.

To sum it up, yes, on first glance, our results look a little bit more modest. We have communicated during the end of 2005 very clearly that, in terms of upfront growth, so to say, we will have first a difficult nine months in 2006 and then should go back to the growth rates we have showed during the last years.

But nevertheless, I believe, if you go into the details, you see a totally healthy state of our major products and also the base business in all parts of the world. This is definitely the basis which makes us very confident for the ongoing year 2006. Jean-Claude.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Jean-Claude Leroy - Sanofi-Aventis - CFO

Thank you, Hanspeter, and good morning, everybody. We will turn now to the first quarter adjusted consolidated income statement. And I will try to clarify about the contribution, particularly, of the selected items in addition to the normal course of business, if I may put it this way.

Let me begin on page 18 by giving words on the net sales. Hanspeter just mentioned a 4.9% growth on a comparable basis. That did translate to 9.6% on a reported basis and it is mainly due to the impact of exchange rates. This 5.4% difference is mainly due to the U.S. dollar, but not only to the U.S. dollar. The U.S. dollar is 3.3 percentage points intact, but there are also other currencies - such as Canadian dollar, Brazilian real, Mexican peso, from one side, the other side of the world, Taiwanese dollar, the Korean won - which impacted positively our reported sales.

If I go down to the gross margin ratio, you can see an improvement by 0.3 percentage points, up to 77.6%. There are two components. Let me begin by other revenues.

There is a good improvement, 19%, which is directly derived by the strong performance of Plavix and Avapro in the U.S. On the other side, what is, I guess, of notice is the stability of cost of goods sold on sales ratio, despite the negative impacts of generics, of Allegra and so on, as Hanspeter just mentioned. So I guess this is the most important part and definitely that means that there are positive impacts, mainly the activity and the product mix, which have balanced these negative impacts.

Going down, on R&D you remember that the performance in 2005, we ended up the full year at plus 2%, with the fourth quarter at plus 6.6%. We reached finally 13.3% during the first quarter of '06 and this is now the direct translation of the financing of these ongoing phase III clinical trials we announced earlier.

In the selling and general expenses area, 6.8%. This is to be put in relationship with the 9.6% of increase in sales. Now, two components. As usual, we give you a small indication. We are facing sustained increase in selling expenses. I mean by that that it is not far from the sales growth in this area, while to the contrary we are on a continuing reduction in G&A, as we were during last year.

A small word about other current operating income and expenses, just to mention that there is an additional item which is in comparison to last year. It's not only the P&G relationship around Actonel. It's also revenues coming with [Frasco], with this U.S. company with which we work on our authorized generics, mainly Allegra. All of that brings us to an operating income current of 2.4b, an increase by 12.9% over last year. And I guess this is representative of the normal course of business increase during that first quarter.

If we go down now to other items from operating current to operating income, then you have big figures in that first quarter - 533m positive impact as compared to the 17m of last year first quarter. Well, mainly, this is derived from capital gain on disposals.

We already mentioned with you in the past the Exubera capital gain we made when selling the Exubera to Pfizer. We, at that time, said that it was something which would bring a capital gain of around 300m after tax. After the closing arrived, as you can see, we come to a figure which is a little higher - 461m before tax - which, we will see later, translates in 384m.

In addition to that, there was another item which is worth mentioning, which is the sale of the remaining stake, 30%, in the Animal Nutrition business, which occurred during the first quarter. And we booked a pre-tax capital gain of 45m. Therefore, the operating income is increasing by 37% to close to 3b.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Let me go down now to the net financial expense, another improvement in this first quarter, which is a 76m difference between 30m and 106m last year. Two components, mainly. First, interest charge on the debt. You see another improvement of around 56m, which is directly derived from the variation of the level of debt of the Company.

On the other front, we had a favorable contribution of financial instruments, 37m versus 10m last year. Remember the two main components, the Rhodia equity swap and the CSL derivative. CSL is the Australian company to which we sold the Aventis Behring business some years ago.

A word about the effective tax rate. What you can see on the first quarter of '06 is a rate at 28.5%, to be compared to 31.8% last year. Now, this year, it is made of two components. The first one is the income tax on the Exubera capital gain. And on this one, we had a 16.6% tax rate on the capital gain. Why so low? Just because you have to remember that, when we signed the contract with Pfizer, we shared, if I may put it this way, the income tax burden. It was determined at that time that the local government taxes would be paid by Pfizer, which explains why it's such a low rate.

If I exclude this capital gain item of the analysis, we come back to 30.7%. And well, you will remember that last year - I mean the full year - we had a 31.3% effective tax rate. I mentioned in February that, because of the Allegra situation in the U.S. and the high tax rate in the U.S., we would have a mechanical decrease in the effective tax rate. That's exactly the situation we're seeing in this first quarter.

Then, a few words about share of profit and loss from associates. You see a good increase over last year. Two components, again - the BMS alliance, again, the Plavix and Avapro situation in the U.S., but also worth to mention the substantial growth once again of Merial. Minority interests, directly driven by BMS - the other way around, this is their share of that territory which we are managing - showing also a good growth.

So, finally, we are coming down to a net income by 2.173b, which shows a 53.6% increase over last year, translates into 1.62 per share, to be compared to 1.06 last year. But I guess that, once again, the analysis is worth to look at the selected items' impact to be more transparent. And as we've shown on this slide, page 23, you see that there is a major impact in this quarter, which comes down to 466m after tax, to be compared to close to zero last year. I mentioned the main components - capital gain and the financial instruments, the derivatives - a little bit earlier.

So it is worth to say that there was a big impact, the reason for which we made the comparison before the impact of these selected items. And excluding those, as you can see, our adjusted net income is showing an increase by 20.4%, which translates into 19.8% on an adjusted EPS basis; in other words, 1.27 per share to be compared to 1.06.

And I guess that here, to finish up, it is interesting to stay a few minutes on this one. Again, I mentioned earlier that there was a positive currency impact from the sales. If we translate that at the bottom line basis, and I will just talk about the U.S. dollar/euro impact. You remember that we said that the sensitivity was 0.6% of gross per cent of difference. You know that there were \$0.11 difference between the \$1.20 conversion rate of this year, to be compared to \$1.31 last year, so directly you can measure the impact of the U.S. dollar bottom line. We are talking of 6.6% of gross, so I don't make the calculation or maybe I make it; you see that the gross on this first quarter out of the selected, excluding the selected items, was closer to 13%.

And I guess that it is a good and fair view of what happened during this quarter, mainly remembering that the selected items are more something which are most volatile and unpredictable. And I guess that, again, that does explain why we are just mentioning our guidance for the full year, which is that plus 10% [inaudible] 1.25 euro to the dollar and with that level of 300m after tax selected items compared to the 165m on the full year last year. Thank you very much.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

QUESTIONS AND ANSWERS

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Okay, operator, we can go to the Q&A session now, please.

Operator

Thank you very much, sir. [OPERATOR INSTRUCTIONS]. Today's first question will be coming from Mr. Tim Anderson of Prudential Securities. Please go ahead, sir.

Tim Anderson - *Prudential Securities - Analyst*

Thank you. A few questions. On Acomplia, are you guys still guiding for a second half '06 launch in the U.S.?

On dronedarone, can you confirm whether the PDUFA date has passed for this product and when we might hear an update from you on what's going on with FDA?

And then, last question, in the quarter you obviously came in well ahead of, I think, everyone's estimates, yet you're maintaining full-year guidance. And I'm wondering what the biggest uncertainties are that lay ahead for the rest of the year that make you reluctant to raise the guidance at this point. And I'm wondering if the biggest swing factor there is launching new products like rimonabant.

Hanspeter Spek - *Sanofi-Aventis - Head of Operations*

Tim, thank you for your questions. On Acomplia, I think we can say absolutely nothing else. We remain confident and prepared to launch Acomplia during the second half of 2005 -- in 2006, excuse me. We remain in a permanent exchange with the FDA.

In Europe, we are very actively now preparing for the first launches. If the usual delays are being respected, which are driven by the purely administrative recognition of the positive opinion which has been expressed on Acomplia, we are confident to launch in the first markets, then, in the period July/August. And those first markets, traditionally in Europe, are the United Kingdom and Germany.

On dronedarone, we are waiting for reactions from the FDA. We can say nothing else because, for evident reasons, we are obliged just to sit and wait and hear whatever from the FDA comes.

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

Okay, on the guidance. Thank you for the question. It's fair to say -- you're totally right that we have to explain a little bit further to you. There are two parts and there will be two parts in my answer.

First, as I mentioned earlier on the selected items area, it is fair to say that we reached 466m after tax at the end of the first quarter. Now, I mentioned that these items are mainly volatile and unpredictable, which, in turn, tells us that we cannot predict exactly where we are going to be, even -- so I have nothing new to report in this area today.

More importantly, the truly business side of the Company now, you mentioned the launch and this is fair and true. Hanspeter mentioned that the launch of Plavix in this month in Japan. Obviously, as of that second quarter of '06, we will put investment behind Plavix in Japan to make a success of this launch.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

In addition to that, because of this approval of Acomplia in Europe, we intend to launch, as again Hanspeter mentioned, during the second part of the year in some European countries. And again, it is fair to say that we will put every mean which is necessary behind this product to make a success.

So we have to expect more commercial and marketing expenses in the rest of the year, proportionately, than we did have during the first quarter, which is the main reason for which we don't move our full-year guidance. In other words, what happened during that first quarter is exactly in line with what we said for the full year.

Tim Anderson - *Prudential Securities - Analyst*

Okay. Thank you very much.

Operator

Thank you, Mr. Anderson. Our next question will be coming from Mr. Philippe Lanone of Ixis. Please go ahead.

Philippe Lanone - *Ixis Securities - Analyst*

Yes, good morning. Three questions, if I may. Number one, can you update us on the Apidra launch and also on the market share of Lantus. From what Nova is publishing, there seems to be a [pattern] expressed in terms of presentation of the analog market in Europe. Could you elaborate on that?

Also, we were expecting some provisions on the Apotex settlement in the first quarter. Can you tell us if there are any and what will be the figures for the next quarters?

And lastly, could you give us some indication on the pricing for Plavix? Has there been any recent price increase? Thank you.

Hanspeter Spek - *Sanofi-Aventis - Head of Operations*

Well, I'll start with Plavix then. Yes, there has been a price increase at the very beginning of the year of 4% in the United States. Unfortunately, for the reasons you are aware of, there are no other price increases outside the United States that will be mentioned. Nevertheless, I mention again the very good price we have obtained in Japan for the ongoing launch.

Now, on Lantus, well, you will understand that I don't want to comment on what [Eventualin] or Novis has been communicating. But once again, if you look to the slide number 13 of our today's slide set, you see the major development in three major markets. And that chart confirms that also in the United States we are continuing to grow and we grow very strongly and we are gaining market share.

On Apidra, things are very, very early. We have a nice prospect and all over [inaudible] sales in the United States and in France, which are the most recent launch markets. We are just two months or three months post launch. We are performing according to our expectations but, given the recent launch schedule, I cannot say much more than this.

Now, on Apotex?

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

On Apotex. I am sure that you -- all of you followed the release of Bristol-Myers on this issue and I can definitely confirm what they did and what they said about that. So, in summary, yes, we did book -- they did book an amount of \$20m, \$20m each,

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

which is the minimum payment which we would have to do to Apotex if in the event that the agreement is finalized. Let me give you just a few words on this one.

You remember that in March we announced a proposed settlement with Apotex related to this litigation. We've since submitted this settlement to the FTC and to the Attorney General for review. Again, we cannot predict at this point on time how long it will take to evaluate the agreement. And, as we indicated in our release, there is a significant risk that the required antitrust clearance will not be obtained.

I can just finish to say that I'm sure that you have a lot of other questions. You asked me how much we would book in the next quarter. All of that depends on the review of the FTC and the Attorney General. And even though then you have questions, I would ask for your understanding that we can't elaborate any more on this subject for the time being.

Philippe Lanone - *Ixis Securities - Analyst*

Okay, thank you.

Operator

Thank you very much, sir. Our next question will be coming from a Mr. Graham Parry of Merrill Lynch. Please go ahead, sir.

Graham Parry - *Merrill Lynch - Analyst*

Hi, good morning. Thanks for taking my questions. Firstly, on Acomplia, can you just confirm that you have had a meeting with the FDA post your approvable letter and that your second half launch guidance is based on the discussions you've had from that meeting?

Secondly, are you hiring additional reps in Europe for the Acomplia launch in the second half of the year?

Third, on Ambien, if you could just give us the split out that's Ambien CR?

And finally, on the FTC settlements, do you have a better feel for when the FTC may respond and any timing there? And if they do reject the settlement, is legal action against FTC an option? Thanks.

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

I will follow up on Apotex. I am sorry but I already mentioned that I won't elaborate any more on the subject, so we can do whatever you want. Let me remind you. This dossier, this file is under review with FTC and the State Attorney General and up until the time we have an answer, we won't elaborate any more on this one. And please just refer to the press release we issued at that time in March and help us to understand that we cannot go any further in this area.

Hanspeter Spek - *Sanofi-Aventis - Head of Operations*

And on the Ambien, you will understand that we don't give splits inside the product families. But as an indicator, you can take [that you] said about 21, 22% of our new patients are being put on Ambien CR, so you -- I think you can easily define from this what happens with IR.

On Acomplia, we don't intend to increase our rep sales force inside Europe consequent to the imminent launch, except perhaps small increases in smaller markets. But in the major markets we do this with our existing forces.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Then, on the ongoing conversations with the FDA, I cannot confirm to you that we had one meeting, as your question has been posed. I said earlier that we are in a permanent dialogue with the agency and I have nothing to add to this. But as also previously stated, yes, we are still planning and we continue to plan for a launch also in the U.S. in the second half of 2006.

Graham Parry - *Merrill Lynch - Analyst*

Okay, thanks very much.

Operator

Thank you, Mr. Parry. Our next question will be coming from Mr. Jerome Berton of Aurel Leven Securities. Please go ahead.

Jerome Berton - *Aurel Leven - Analyst*

Yes, good morning, gentlemen. Just a quick follow-up question with regard to Plavix. Could you update us on your ongoing discussions with Dr. Reddy's, please?

Hanspeter Spek - *Sanofi-Aventis - Head of Operations*

Sorry, once again, on this issue of the Plavix litigation and agreement with Apotex and so on, just repeating what we said and wrote in March, that we made contact with Dr. Reddy's just after signing the agreement with Apotex. And I will stay at that stage, once again, on the global subject of this litigation and settlement.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Can we have the next question, please?

Operator

The next question will be coming from Mr. Sebastien Berthon of Exane. Please go ahead.

Sebastien Berthon - *Exane BNP - Analyst*

Yes, good morning, gentlemen. A few questions on the one-offs for this quarter. They are 44m in other divestments apart from [inaudible] Animal Nutrition and Exubera. Are there any specific items there?

And also, on the financial non-recurring items, you put the 30m on there. Could you give us a split of any specifics on Rhodia and CSL?

And on the Apotex payment, if I understand well, the \$20m you took in Q1. In what line of the P&L is that?

And lastly, could you give us the sales of Ketek and Apidra in this quarter, please?

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

Okay. First, the capital gain you were referring, it's pre-tax 45m capital gained by -- when selling this remaining stake once again of the Animal Nutrition activity, which belonged to the Aventis area world in the past, so I can confirm.

On this other two, the 30m investment [inaudible] in the financial instrument and other, I can confirm the two components once again, which are first the Rhodia derivative and second the CSL derivative. I have to add up that on the Rhodia side the contract ended up in [Avro], so it's about the last time we're talking of that -- of this item. And again, I confirm these were these two elements of the components of these line items.

On the payment, the reserve for payment to Apotex, we booked \$20m before tax. Obviously, we made it afterwards, so that's after tax and in euros, and it is in the line item of the income coming from associates.

Hanspeter Spek - *Sanofi-Aventis - Head of Operations*

Now, on your two questions concerning sales, quarterly sales of Ketek have been 64m and Apidra 8m.

Sebastien Berthon - *Exane BNP - Analyst*

Thank you.

Operator

Thank you very much for your question, sir. We'll now go to Mr. John Murphy of Goldman Sachs. Please go ahead, sir.

John Murphy - *Goldman Sachs - Analyst*

Yes, good morning. I have two questions, please. First, can you talk a little bit more about performance in France and maybe give us a bit more background to the dynamics, please, in that now difficult market?

And second, as you mentioned there, your patent drag eases in the fourth quarter of the year and so we should see top line growth coming back more strongly. What we've also seen with other companies when they've gone through periods like this, though, there's also been a strong acceleration in earnings growth. Now, with the caveats of the launch costs around Acompla, for example, in the U.S., is there any reason why we should not also anticipate an acceleration in earnings as well, when we see that -- as we move into next year?

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

Well, if I take the last one, again, the structure of -- even though, as you know, we don't give any forecast on a quarterly basis, we had that yearly guidance and we want to stick to that way of giving you figures. For the next year, I said that -- earlier that there are these launch costs which are to be taken into consideration for the rest of the year.

Yes, obviously, if you take on a quarter-per-quarter comparison, as you may say that the fourth quarter should be better than the rest, because we are comparing something which is more comparable at least from the sales level. But globally, and we want to stay and remain global, it is fair to say that the plus 10 -- around plus 10% is the figure we want to keep for the rest, for the global year. And when it comes to 2007, you will understand that I have nothing to say at that stage.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi-Aventis - Head of Operations

Now, on France, of course you know that we don't give a split on our sales in France. But, nevertheless, yes, this is a serious situation we are facing, together with the industry in France. I just can repeat what the major issues of these interventions by the French government are. So, first of all, it's an increase of a so-called tax on drug sales, which has been previously 0.6% and now is going up to 1.76%.

Then we have suffered a price decrease of 15% for all of those products which are no more covered by a patent. Then there has been further sharpenings of the system in place concerning reference prices, the so-called -- the TFR. There is an encouragement of generic substitution. There has been a reimbursement of nearly 160 pharmaceutical products, out of which also some of our products. And I may add that no major product of our portfolio has been concerned by this measure. And there will be some additional measures to be expected on the hospital market.

So, what to say, first is the government once has issued a target of 2.8b as overall savings coming from the pharmaceutical industry. Our market share in France is, as you probably know, about 17%. So this gives you a very, very rough estimate of what we have to compensate.

Now, the only positive thing I can add to this is that, to a large extent, we had anticipated this in our budget for 2006. So you may consider that, despite the severity of those measures, it is incorporated into our guidance, as reconfirmed previously by Jean-Claude.

John Murphy - Goldman Sachs - Analyst

Thanks very much.

Operator

Thank you very much, Mr. Murphy. The next question will be from Alexandra Hauber of Bear Stearns. Please go ahead.

Alexandra Hauber - Bear Stearns - Analyst

Thank you very much. Good morning. Firstly, on Ambien, it seems like your conversion seems to be stalling a bit. It has been around 19, 20% for the last eight, 12 weeks. Do you plan any major initiative to give that some new impetus?

Secondly, I was wondering on your pediatric vaccines, you mentioned strong polio sales in the international zone. Is that just a one-off -- was that a one-off contract or is that a new sustainable level going forward?

And I was also wondering whether you could comment on the billion or so HHS contract which you have seen yesterday for cell culture. You didn't get any further award after last year's award. But it seems the amounts are -- basically, I cannot figure out how the amount has been allocated. I was wondering whether you could shed some light into that.

And also, whether you could let us know when you will be booking your pandemic flu contracts. You said before upon shipment, but I was under the impression you're going to -- you store this into this quarter anyway, so technically there will be no shipment. Does it mean you're not going to book those sales at all this year?

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Jean-Claude Leroy - Sanofi-Aventis - CFO

If I begin by the last question, we did not add any sales from H5N1 in the first quarter. So this is to come during the remaining of the year. I cannot predict exactly what is going to be the pace or the split between quarters. That I don't know. But we should be booking this contract during the rest of the year.

On the other question related to the 1b grant which was given yesterday by the U.S. government, yes, we didn't get anything. Sanofi Pasteur didn't get anything. I remind you that last year we got that \$93m reward for the cell culture. I won't say a lot on this one, except that you have to remember that these grants are actually paid on a milestone basis, depending on the results of the various trial phase of any trial. And the report, the rest -- the allocation for 2006, yes, are done but the root program of the U.S. government is not totally done.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Let me just add that the amount put aside by the U.S. government in 2006 is more than the combined amount in '03, '04 and '05. And, given that we were the first beneficiaries in 2005, we were actually not eligible for this program, this first series of grants in 2006. But we are on track with the cell culture program. You know we have indicated our intention to start trials before the end of this year and we expect to finalize the cell cultures some time towards the end of the decade.

Alexandra Hauber - Bear Stearns - Analyst

And, sorry, this is just a general question. Because the amounts, they look almost -- I'm sure they're not random but that's how they look like. Do companies -- how do they work? Do you apply for specific programs and then you get a grant according to the size of the program? Or is it just a top-down decision which allocates certain amounts to certain companies?

Sanjay Gupta - Sanofi-Aventis - Head of IR

I think there is a procedure which confirms RPF and discussions and we went through the procedure last year. But I'm not aware about what the process was for the current year.

Alexandra Hauber - Bear Stearns - Analyst

Okay.

Hanspeter Spek - Sanofi-Aventis - Head of Operations

Now, on Ambien, yes, Alexandra, I agree we -- I would not say stalled, but we have a slowdown during the last four to eight weeks in conversion. We believe there are two reasons. The first one is the one I mentioned earlier, which means the negative press the whole class and we had was, of course, not at all encouraging further switch between IR and CR.

The second one, and this is one we have very actively addressed, is the difference in reimbursement between IR and CR. As you probably know, the question is to which extent you are in second tier reimbursement. Naturally, IR is still in a more favorable position than CR. And by adequate means in our commercial policy we have addressed this issue in the very recent weeks and we see very nice progress in moving more CR into second tier positions. And I'm relatively confident that this will translate in a reacceleration of switch rates during the second quarter.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Alexandra Hauber - Bear Stearns - Analyst

So, could you quantify how many of -- how many formula is carrying it in large percentages of --?

Hanspeter Spek - Sanofi-Aventis - Head of Operations

No. No, but significant.

Now, last point on pediatrics, there is nothing substantially new. I can just, in general terms, say that we remain very confident concerning this program but, once again, we are in the hands of the FDA. But I can confirm that we are doing everything to deliver [inaudible] data in the time.

Alexandra Hauber - Bear Stearns - Analyst

Sorry, I wasn't actually asking about the pediatric vaccines. I don't know whether --

Hanspeter Spek - Sanofi-Aventis - Head of Operations

[Inaudible].

Alexandra Hauber - Bear Stearns - Analyst

Yes, because there was a strong acceleration and you mentioned strong polio sales in the international zone in slide five. So I was wondering if there was a special one-off contract or whether it's just much, much above previous year's levels.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Yes, this is basically linked to oral polio vaccines and you know the sales can fluctuate from quarter to quarter, depending upon when you get [inaudible] from Unicef and other international organizations. So it's essentially OPV sales which are the component. But the fact that our pediatric vaccines continue to grow nicely in Europe, and you know that Pentacel is currently undergoing a review in the United States and we will expect to hear about it some time next year.

Alexandra Hauber - Bear Stearns - Analyst

Okay, thank you.

Operator

Thank you for your question, Miss Hauber. Our next question is coming from Mr. Paul Mann of Deutsche Bank. Please go ahead.

Paul Mann - Deutsche Bank - Analyst

Hi. Just -- most of my questions have been asked, actually, but just can you reconcile the difference between prescription growth and revenue growth for developed Avapro sales and Plavix sales? It's clear that a price increase of 4% on Plavix and probably a price increase on Avapro, but also there's been a change in rebates, maybe some stocking and some currency impact as well.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi-Aventis - Head of Operations

Well, on Avapro, yes, there has been a change in policy and you probably have followed the call on -- from BMS on the same subject. And we have benefited from a certain switching of our commercial policy to major accounts. If you look to the Plavix performance, it is relatively easy. You just take the prescription total, you add to it the price increase, which has been 4% as mentioned earlier today, beginning of this year. There is a very slight stock reduction on top of it and then you more or less have the exact figure as reported in our sales growth.

Sanjay Gupta - Sanofi-Aventis - Head of IR

As I mentioned, that BMS also indicated in its conference call that they had some changes in [inaudible] so that had an impact.

Operator

Mr. Mann, does that answer your question, sir?

Paul Mann - Deutsche Bank - Analyst

That's okay, thanks. Yes.

Operator

Thank you very much, sir. We now go to Jo Walton of Lehman Brothers. Please go ahead.

Jo Walton - Lehman Brothers - Analyst

Good morning. I wonder if you could tell us a little bit more about the gross margin. Considering that you've lost so many products, you've sustained your gross margin extremely well. Is this something that you can continue for the next three quarters, until the generic situation has gone? Is this something to do with foreign exchange?

Could you also please tell us, you mentioned that Merial had done well. Has the Sanofi Pasteur vaccine joint venture also done equally well?

Jean-Claude Leroy - Sanofi-Aventis - CFO

Okay, I'll start the gross margin. I guess that your question is directly related to the cost of goods in the P&L. You're right there. We had that good comparison versus last year, which is also, by the way, a good comparison with the fourth quarter of 2005 because it shows an improvement.

Are we capable of sustaining? What is -- another effect is that [TVT], I should have said volume, which in terms is the same explanation. We had good volume because when we are talking generally of the sales evolution out of the generic, you've seen through the Hanspeter explanation that we've kept around the same kind of volume evolution so far. For the remaining of the year, I said in February that more or less we should keep the same kind of cost of goods sold for the year. So I won't change the answer and I guess that the first quarter about demonstrates that.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi-Aventis - Head of Operations

If I may just add that to this, Jo, we have stressed from the very beginning, I mean the beginning of Sanofi Aventis, that we give a large priority to our industrial activity by reintegrating volumes which have been given outside our own industrial perimeter, which we have meanwhile reintegrated. So, to a certain extent, you see a very nice increase of our industrial occupation also reflected in this cost of goods and subsequently gross margin percentage. And, yes, we will continue to exercise this policy of doing everything to occupy our own factories by reintegrating and, of course, driving our volume.

Jean-Claude Leroy - Sanofi-Aventis - CFO

What was your other question?

Hanspeter Spek - Sanofi-Aventis - Head of Operations

Merial and Sanofi Pasteur.

Jean-Claude Leroy - Sanofi-Aventis - CFO

Okay. So, what can we say about Sanofi Pasteur? We can give a word about the sales structure of the JV. And in this area -- I'm just looking for the exact figure. Sorry, just a sec, here we go. On the first quarter, the sales of the JV were 144m. It's a 12.5% increase over last year.

You may remember that we had that [Exabac] setback during last year. So, again, we made the comparison just to give you a better understanding of how the business is running out of that. And we said -- and we are on a reported basis that, if we were to exclude Exabac from the comparison, we would show up a 35% increase in sales. And this is a bit new to the pace of development of the JV in Europe. So we are having a good evolution in sales, as well as we do in the rest of the vaccine business.

Jo Walton - Lehman Brothers - Analyst

Thank you.

Operator

Thank you, Ms. Walton. We'll now go to [Michael Luchton] of HSBC. Please go ahead.

Michael Luchton - HSBC - Analyst

Thanks for taking my question. I just had one on Lovenox in the U.S. Certainly the product seems to have broken a growth trend in dollar terms, excluding the exchange rate impact. And I was wondering whether that's really truly underlying or whether there is anything one-off for the quarter in there.

Hanspeter Spek - Sanofi-Aventis - Head of Operations

I did not phonetically get the end of your question. Could you please repeat?

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Michael Luchton - HSBC - Analyst

I was just wondering, the strong performance in dollar terms of Lovenox for the first quarter, I was wondering whether that's truly underlying or whether there is a first quarter impact and that it will not be -- or would not be sustainable going forward?

Hanspeter Spek - Sanofi-Aventis - Head of Operations

No, no. No, absolutely not. There are no one-time events or major changes in pricing policy, unfortunately perhaps. No, it is really truly reflecting the actual performance and the clinical medical usage.

Michael Luchton - HSBC - Analyst

Thank you.

Operator

Thank you very much, sir. We'll now go to Kiyoshi Ando of Nikkei. Please go ahead.

Kiyoshi Ando - Nikkei - Analyst

Good morning. I have a question concerning Plavix launch in Japan. Can you give me roughly what is the market size that you're looking for in Japan for this drug? And do you think that this will boost your overall market share in the country, as other foreign companies are doing recently?

And secondly, concerning vaccine business, some foreign companies are starting to see Japan as a good market for that as well, and plan for the clinical studies in Japan. Do you think that kind of study is possible in the near future?

Hanspeter Spek - Sanofi-Aventis - Head of Operations

Well, first I'll take the vaccines. First, I would agree and we will agree that, yes, Japan of course is a very interesting market for all those reasons, which means pandemic, epidemic. We see this now real innovation possible in the field of vaccines, consequently higher prices, higher margins. On the other side, pressure on healthcare costs and some [inaudible].

On the other side, I think it's fair, once again, which is not unusual for Japan, to underline that the access to the Japanese market is a little bit more complicated than to other markets. There are some strong local companies in this respect, as there is a lot of joint venture activity. But the overall judgment we entirely share with you, that Japan also in this respect is getting more attractive.

Now, on Plavix, well, we have not given a guidance on our targets this year with the Plavix launch. Nevertheless, two references. Ticlopidine, before the usual policy of price reduction has been applied, was a product achieving more than 400m. Of course, there's first of all the price difference now between ticlopidine and clopidogrel, as also mentioned earlier. And, yes, there is a different profile because clopidogrel is a product that's presenting much less of a potential risk in terms of side effects, and it's got a potentially larger clinical usage of clopidogrel as compared with ticlopidine.

So, overall, I think it is clear that we are expecting sales on a, let's say, four, five year basis between 0.5b and 1b coming out of Japan.

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Kiyoshi Ando - *Nikkei - Analyst*

Thank you.

Operator

Thank you, Mr. Ando.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Can we take a couple of questions, please?

Operator

We have the next question is from [Eileen Robert] of La Tribune. Please go ahead.

Eileen Robert - *La Tribune - Media*

Good morning. I have a question about the arbitrage process going on with Rhodia, as it is supposed to be -- a decision is supposed to be taken this year. I wanted to know if you had booked any provision on the subject, as Rhodia is claiming 600m from you.

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

Okay. Generally, we don't give any detail on our risk and what we put in the books. As an exception, remember that we already said officially to one question last year that we didn't book anything as far as the Rhodia arbitrage potential consequences may be for Sanofi-Aventis. So today I can confirm that we have not changed our policy. So, no, we have no reserve for this situation in our books.

Eileen Robert - *La Tribune - Media*

Okay, thank you.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Okay, can we have one last question please?

Operator

Yes, sir. The last question for this conference is to be coming from Michael Leacock of ABN Amro. Please go ahead, sir.

Michael Leacock - *ABN Amro - Analyst*

Thank you. I have a few brief questions. Firstly, on the European filing or recommendation for approval for Rimonabant, you've also got the name Zimulti, which apparently took an 85-day review time. Is that mainly a brand name difference or is there some other difference there?

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

Secondly, I wonder if you could just share with us the generic landscape for Loxetine. I think the patent certificate expired in April in '06 in the U.K.

And thirdly, I believe you were due to have a final decision on the Albemarle arbitration. That's the environmental issue. I wondered if that's happened. I think it was due for Q1 '06, and if you could give us a guidance of what sort of scale of charge there might be there.

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

I will take your last question. Same that you've seen, this is true that we -- there was a court hearing on this subject, which is related to the environmental cost on this Albemarle site. And the question was who was to pay for these costs. And the court said that we and Albemarle have a certain period of time to come up with agreement, otherwise the answer would be given by experts. And we are just in that period where we have to discuss with Albemarle, to try and come up to a common view of how much is to be charged for each company.

Hanspeter Spek - *Sanofi-Aventis - Head of Operations*

Now, on Eloxatin and Loxetine, we have to differentiate in our answer. First of all, there is an end of data exclusivity. Second, there is a process patent. Third, there is a solution patent. And on top of this, all those data vary from market to market. So the end of exclusivity is usually by the end of '06. The process patent lasts until 2013 and the solution patent even to 2015.

Nevertheless, I think it is clear that in some minor markets we have to expect generic competition on the solution -- excuse me, not on the solution, on the [lioform] by the end of 2006. As, for example, in the Scandinavian market there has been recently an application for such a product in Finland.

Now, the last question then, really on Zimulti, that's a very easy one. Zimulti is a secondary trademark. We have applied for two registrations on the European level. But I can confirm that in Europe it definitely will launch under the already well-established trademark of Acomplia, and that Zimulti is nothing but a secondary trademark we may use later on for technical reasons.

So, at this point of time, I may, in the name of my friend Jean-Claude Leroy and Sanjay Gupta, thank you once again for your attention, for your questions and for your interest in the Company. You may be sure that we will do our very, very best to confirm in the upcoming quarters what we have been able to show in the first one.

Thank you once again for your attention and have a good day. Bye-bye.

Operator

Ladies and gentlemen, that will conclude today's conference. Thank you very much for your participation. I wish you a great day.

FINAL TRANSCRIPT

May. 05. 2006 / 2:00AM, SNY - Q1 2006 Sanofi-Aventis Earnings Conference Call

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2006, Thomson Financial. All Rights Reserved.

Exhibit R



sanofi aventis

Because health matters

ACOMPLIA® (RIMONABANT) RECEIVES MARKETING AUTHORISATION IN THE EUROPEAN UNION

***First-in-class CB₁ blocker approved for the treatment of obese patients,
or overweight patients with associated risk factors,
such as type 2 diabetes or dyslipidaemia***

Paris, France – June 21, 2006 – Sanofi-aventis announced today that the European Commission has granted marketing authorisation for ACOMPLIA® (rimonabant 20 mg/day) in all 25 European member states. ACOMPLIA®, discovered and developed by sanofi-aventis, is the first in a new class of drugs called CB₁ blockers. ACOMPLIA® is indicated as an adjunct to diet and exercise for the treatment of obese patients (BMI $\geq 30\text{kg/m}^2$), or overweight patients (BMI $>27\text{kg/m}^2$) with associated risk factors, such as type 2 diabetes or dyslipidaemia.

The marketing authorisation was based on the review of comprehensive efficacy and safety data, including data from the RIO clinical trial programme which involved more than 6,600 patients worldwide, of which over 4,500 were studied for up to two years. Results from the RIO programme demonstrated that one ACOMPLIA® 20 mg tablet taken every day significantly decreased weight and waist circumference, HbA_{1c}, and triglycerides and increased HDL-cholesterol levels. Importantly the label granted by the European Commission states that an estimated 50% of the observed improvements in HbA_{1c}, HDL-cholesterol and triglycerides were beyond that expected from weight loss alone.¹

“The approval of ACOMPLIA® in the European Union is important news for obese and overweight patients with additional cardiometabolic risk factors such as type 2 diabetes or dyslipidaemia who will now have access to an innovative treatment option,” said Jean-François Dehecq, Chairman and Chief Executive Officer of sanofi-aventis. *“Through our discovery, development and now this approval of ACOMPLIA®, sanofi-aventis has once again demonstrated our expertise and commitment to making first-in-class treatments available to patients and physicians alike.”*

ACOMPLIA® 20 mg is targeted at improving multiple cardiometabolic risk factors in obese and overweight patients. Those likely to gain most benefit will be patients presenting with abdominal obesity (a large waist circumference) who also have diabetes and/or dyslipidemia. Almost half the adult population with a large waist circumference (defined as 102 cm/40 inches in men and 88cm/35 inches in women) present with at least 3 additional risk factors, all contributing to increased cardiometabolic risk.

Global cardiometabolic risk represents the overall risk of developing type 2 diabetes and/or cardiovascular disease and is due to a cluster of modifiable risk factors. Cardiometabolic risk factors include classical risk factors such as high LDL-cholesterol levels, hypertension and hyperglycaemia and emerging risk factors closely related to abdominal obesity (especially intra-abdominal adiposity), such as insulin resistance, low HDL-cholesterol, high triglyceride levels, and inflammatory markers such as adiponectin and CRP (C-reactive protein).



sanofi aventis

Because health matters

press release

"Until now we have not had a medication that addresses the multiple cardiometabolic risk factors that put patients at risk for cardiovascular disease and type 2 diabetes," said Luc Van Gaal, M.D., Professor of Diabetology, Metabolism and Clinical Nutrition, Antwerp University Hospital, Belgium and Principal Investigator of the RIO Europe trial. "Rimonabant is an important advance to treat the multiple risk factors which contribute to the global risk for diabetes and cardiovascular disease, which will offer benefits beyond current treatments for individual risk factors such as blood pressure, cholesterol and diabetes."

ACOMPLIA® will be available in European Union countries for prescription as a 20 mg tablet to be taken once daily. The first launch of ACOMPLIA® will take place in the United Kingdom in July 2006 and will be followed by launches in Denmark, Ireland, Germany, Finland and Norway during the second half of 2006.

Safety and Tolerability

ACOMPLIA® 20mg has been evaluated for safety in over 6,300 patients. In placebo controlled studies the discontinuation rate due to adverse reactions was 15.7% for patients receiving ACOMPLIA®. The most common adverse events resulting in discontinuation were nausea, mood alteration with depressive disorders, anxiety and dizziness.¹

ACOMPLIA® should not be initiated in patients with hepatic or renal impairment or patients with uncontrolled serious psychiatric illnesses such as major depression.¹

About ACOMPLIA®

ACOMPLIA® works by selectively blocking CB₁ receptors found in the brain and in peripheral organs important in glucose and lipid (or fat) metabolism, including adipose tissue, the liver, gastrointestinal tract and muscle.² CB₁ receptor blockade with ACOMPLIA® acts to decrease the overactivity of the endocannabinoid system (EC system).^{3, 4} The EC system is a recently characterised physiological system that includes receptors such as the CB₁ receptor, and it is believed to play an important role in regulating body weight and in controlling energy balance, as well as glucose and lipid metabolism.⁵

About sanofi-aventis

Sanofi-aventis is the world's third largest pharmaceutical company, ranking number one in Europe. Backed by a world-class R&D organisation, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine and vaccines. Sanofi-aventis is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally



sanofi aventis

Because health matters

press release

identified by the words "expect," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

References

¹ ACOMPLIA[®] Summary of Product Characteristics

² Pagotto U. Fighting obesity and associated risk factors by antagonising cannabinoid type 1 receptors. *Lancet*. 2005 Apr 16-22;365(9468):1363-64.

³ Van Gaal et al. Effects of the cannabinoid-1 receptor blocker rimonabant on weight reduction and cardiovascular risk factors in overweight patients: 1-year experience from the RIO-Europe study. *Lancet*. 2005 Apr 16-22;365(9468):1389-97.

⁴ Di Marzo V, et al. Leptin-regulated endocannabinoids are involved in maintaining food intake. *Nature*. 2001;410 822-825.

⁵ Pagotto U. The Endocannabinoid System: A New Player in Reinforcement and Energy Control Functions. Poster presented at the Metabolic Syndrome, Type 2 Diabetes and Atherosclerosis Conference, Marrakech, 19 – 23 May 2004.

Exhibit S

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Event Date/Time: Aug. 02. 2006 / 2:00AM ET

FINAL TRANSCRIPT

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

CORPORATE PARTICIPANTS

Sanjay Gupta

Sanofi-Aventis - Head of IR

Hanspeter Spek

Sanofi-Aventis - EVP, Pharmaceutical Operations

Jean-Claude Leroy

Sanofi-Aventis - CFO

CONFERENCE CALL PARTICIPANTS

Tim Anderson

Prudential Securities - Analyst

Eric Le Berigu

Raymond James - Analyst

Amit Roy

Citigroup - Analyst

Jo Walton

Lehman Brothers - Analyst

Jerome Berthon

Aurel Leven Securities - Analyst

Michael Leacock

ABN Amro - Analyst

Graham Perry

Merrill Lynch - Analyst

Ryan Bordeaux

UBS - Analyst

Peter Dullmann

Sal Oppenheim - Analyst

Kiyoshi Ando

Nikkei - Analyst

PRESENTATION

Operator

Good morning, ladies and gentlemen, and welcome to today's Sanofi-Aventis 2006 half year results conference call. [OPERATOR INSTRUCTIONS]. At this time, I would like to turn the call over to your host today, Mr. Sanjay Gupta, Head of Investor Relations. Please go ahead sir.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Good morning everybody. Thank you for attending our conference call this morning. I would like to begin by taking care of the legal requirements. During this conference call we may make projections and forward looking statements that are based on management's current expectations, but actual results may differ materially due to various factors. For additional information about the factors that affect our business, kindly refer to our forward looking statements in our 20-F and our reference documents.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

The format of today's call will be a short presentation, followed by a Q&A session. Mr. Spek, Head of Operations, will now comment on business during Q1 -- Q2, sorry.

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Yes, good morning. As Sanjay indicated, I will try to guide you through the performance very well, understanding that your excitement probably is directed into the increase of our guidance, and you definitely may have a number of questions on the economic situation but we'll get to this. Please understand that first of all I would like to share with you the performance of the second quarter and the first half of 2006.

I suppose we are working together on the slide pack which has been sent to you, and then let's start on page number three. Well, the first half, and more specifically, the second quarter of 2006, I would summarize as seeing two less positive events, the healthcare reforms in France and Germany, and the continued impact of the loss of products that occurred during the second half of 2005 from [inaudible]. And the subsequent generification still leaves its mark on our sales figures and now our sales growth.

On the positive side, there was the launch of Plavix in Japan and very, very recently, the launch of Acomplia in the United Kingdom. How did that translate? Well, you see that for the first half, we have an overall sales growth of 4.5% and you evidently see that vaccines, as communicated and announced previously, have significantly contributed to this growth. It is more than 44% of sales growth.

Relatively modest the growth of Pharma, with 2.1%, respectively 1%. Why? Largely for those two events I mentioned, generification during the second half of 2005, and healthcare reforms in Europe. So you also see this impact when you go to the geographical split. You see then that during we had in the first half a growth of 2.7% in Europe, the growth went to close to zero for the second quarter, and again, this is now the impact of what we have seen and suffered. First of all from a chronological standpoint in France, where a number of measures have been taken at the beginning of the year, such as the increase on tax on drug sales, such as targeted price decreases, such as de-reimbursement and other measures which had a significant impact, not only on our French subsidiary but overall in Europe.

What happened in the first quarter in France happened more or less in the same manner during the second quarter in Germany. You are probably aware that there has been announced a price freeze for a number of years. There have been changes in the rebate system. Those products which have identical activities increased into other products are subject to a 10% rebate and the already existing 6% rebate for patented [data] products have been confirmed, and there have been sharp cuts in a number of [inaudible] prices and we have been touched by this. The consequence, especially in Germany and the 7% loss in the first quarter in France, we have seen de-stocking of wholesalers in anticipation of those measures which were especially true for the month of July.

Now, on the U.S., you see a growth of 3% for the first half year, and 6.6% for the second quarter, and you see then this double digit growth for the rest of the world.

If I may ask you to switch now to page four, there we have illustrated the generic impact in the United States. And as it becomes quite clear from the chart, you see that if you extract the impact of those products being subject to generification at the end of 2005, which are Allegra, Amaryl, Arava and DDAVP, you see that we still had a two digit growth rate, and a very strong one even of 23 respectively, 30% and this is in front of a market which is today at around 6.57%, so it's in value in the United States.

During the last conferences I have stressed our opportunities and our strong market positions in the so-called rest of the world, which is Asia Pacific, Africa and Latin America. And if you now to page number five you will see that this translates, meanwhile, and very significant contributions to growth in very simplistic terms. You see that the growth coming from the so-called rest of the world nearly reaches the magnitude of the United States, an element which makes us very positive and optimistic for

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

the future. Always keeping in mind that also the growth for the United States will come back by the end of this year when we have gone through the negative impact of generification.

On page six, then, again, the portfolio of the leading 15 products in simplistic terms, you see that despite Depakine and Nasacort, and the two generic products, Allegra and Amaryl, you see a high 2 digit growth, and once again, this exercise, if you take Allegra and Amaryl out, you see a growth rate of this part of the portfolio of approximately 15%, which is perfectly in line with the growth we have shown in the first quarter, and by the way, overall, it's very much in line with the growth we have shown for 2004/2005 which has been already between 15% and 20% growth for the leading 15 products.

Now some comments on Allegra first -- no, on Acomplia first. On page seven, you will see the indication, and in fact, we are very much content with this indication as obtained by the European authorities. It is what we have hoped to obtain. And in essence, it is so because a third confirmation of an independent effect of Acomplia on the metabolic parameters, independent of loss of weight, and in essence, we understand the effect on -- of our reimbursement strategy.

On page eight, we have put up some figures which strongly illustrate our confidence in the success of this launch. You see that the market, the key markets are U.K., where we have launched three weeks ago, Germany, where we will launch in three weeks from today, and the U.S., where we are still hopeful and confident to launch before the end of 2006. Those are the three major markets and are very well prepared. There is a high degree of awareness, and there is also already today a high degree of credibility for our product positioning.

You see further on the bottom of the page that the patient types are already today very well identified. This is of course is of major interest for us in order to guide this brand in the good directions there where the product will have the biggest impact on public health.

Now, we have no direct figures for the launch of the United Kingdom, so I have to remain vague. I can just indicate that we have a very, very positive first response from the doctors which have been visited during the last three weeks. You will understand that we of course benchmark with our previous major launches in the U.K. and what we see so far is doing better than those major launches. So we are very, very confident in terms of those reactions, but please understand that precise results, we can only deliver them during the next quarter.

On page nine, the situation of Ambien, we had the obligation during recent quarters to talk about less favorable results for Ambien, and we are glad and proud to report that the product has come back to a very good trend. You see that on the left side that in new prescriptions, we have taken over the growth of the market.

I may also add that we have taken over quite recently [Lonesal], once again in terms of new prescriptions. And so what we see overall for the family is very, very positive, in total prescriptions a growth of more than 10% and you will see them on the right side, that we have meanwhile increased our conversion to more than 24%. So you put this in context, it means our very large confidence that it will be a prolonged protection of the product due to the [inaudible] extension. We are still very positive in the sense that by the end of the protection we will get very close to those approximately 50% of conversions which we have issued across maybe one and a half years ago.

Lovenox had an important growth driver product, growing by margin 14%. Basically, nothing really new. Of course, the U.S. market remains absolutely key. And you see on the right side of page number ten that we have very positive trends in medical patients, which are by far the most important, but also in DVT and in NSTEMI patients.

Plavix, also in Plavix on page 11, we are back to very good trends. The second half of 2005 there had been some concern. We have reported that we have adjusted our marketing measures, especially for hospitals. And as you see there, we came back from growth rates of below 10% to growth rates now close to 15% and this [inaudible] extension led to an overall worldwide growth rate of nearly 18%. And we have seen a little bit less of a performance in the second quarter and in the first half in Europe than in the U.S. which is a, so to say, collateral damage of the various interventions from public healthcare providers in France

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

and in Germany. But if you look outside those countries, you see a picture which is perfectly in line with our nearly 20% growth on a worldwide basis. Nevertheless, we remain very, very positive on the future for Plavix, as you see on page 12.

We have obtained a fabulous penetration in PCI of more than 90%. This is a lead indication of course, but the number of patients is relatively small -- a small indication too. And you see that [inaudible] ACS we have obtained nearly 50% of the theoretical potential and in other indications, even less than 25%. So there is a lot of room to grow and together with [inaudible], we need to further exploit this also through ongoing clinical trials.

Then on page 13, Lantus, growing by nearly 40%. It's good to have the weekend reports that are due in June. We have taken over the lead in the U.S. insulin market, the overall insulin market, and we see that the overall growth of this product has a nearly linear manner. So also in terms of Lantus we remain extremely confident concerning future growth. And if you look at the bottom of the chart on the right side, you will see that a competitive introduction continues to significantly really penetrate this market.

Looking at the oncology portfolio, Eloxatin on page 14, a growth of more than 17% worldwide is not too much different in terms of growth between Europe and the United States. I'm sure you will ask questions on the upcoming generification of Eloxatin in Europe and I am of course ready to answer to this. In terms of penetration you will see that the Adjuvant Stage III is the lead indication but we also continue to grow in metastatic colon-rectal cancer.

Taxotere, Taxotere has been another subject of discussions amongst us. We see the signs of recovery as outlined on the right side. This is very early data, so it's patient data. We don't necessarily see this so far in the [sales] -- in the performance of the product in the United States, but we believe that this will translate during the third and the fourth quarter, also with a stronger sales increase. We have a lot of new data around Taxotere. The recent [congresses] have been very positive for this product, new indications, and fast track provisions by the American Health Authority. So all of this together results in early signs in first line metastatic breast cancer and Adjuvant breast cancer, and makes us very optimistic for the accelerated sales growth to be then reported hopefully during the third and fourth quarter. Overall, nevertheless, the product was also in two digit growth so that growth was 11%.

Well, I have commented on the significant impact, meanwhile, the Vaccines business has on our overall performance. You see on page 16, it is once again illustrated which are the important events. You will see that there has been an impact of \$150m coming from the contract fulfillment that was the American government. Which is to a certain extent, an exceptional event during the first half, but only to a certain extent because we continue to supply the U.S. and other governments with this huge products.

You see that further [sets], especially Menactra, continues in a spectacular way to contribute that to this growth. And we had some [inaudible] indications that we have quite recently, together with [inaudible], have received a positive opinion on Gardasil. The product is now imminent for launch and I hope that the European member states have to recognize the positive opinions, so traditionally it takes a couple of weeks but we are absolutely confident that the product will be actively promoted by the sales forces of Merck and Sanofi-Aventis during the remainder of this ongoing year 2006 and the sales expectation from this portfolio are significant.

So far on sales, and I must pass the ball onto Jean-Claude Leroy, our CFO, who will go into the figures in the profit and loss and balance sheet.

Jean-Claude Leroy - Sanofi-Aventis - CFO

Good morning, everybody. Thank you Hanspeter. Yes, I will go and begin to go through the P&L on page 17 and 18 and I will skip the following pages and come to this schedule. Well, first I guess top-line is to be translated into reported basis, so as you have seen at the reported basis, it's +5.9 on the second quarter and +7.7 on the full first half.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

If we give a look to the gross margin ratio, you can see that this ratio is a little bit lower than last year, at 78.4, to be compared to 78.8%, but now I guess the better comparison is to be made between the first quarter of this year and the second quarter, just because of the fact that these two quarters were impacted in the same manner by the generification of our four products in the U.S. And as you can see, the cost of goods is in line, and I'd say the cost of goods which is only part of that gross margin ratio. The other revenues, which are, I remind you, mainly the royalties on Plavix and Avapro in the U.S. are increasing in line with the performance of other products in this territory.

As far as the H1 is concerned, you see the same label of gross margin ratio as compared to last year, which in turn means at the same time that increases in other revenue, in royalty from the U.S. in Plavix and Avapro which offsets a more burdensome cost of goods because of the generification by half a percentage point.

R&D expense, actually no news from the quarter. I mean by that that we had EBIT program which was, and which is under development because of the success of last year in Phase IIB, so we are increasing our expense by up to 12% in Q2. And that has been a 12.7% increase in the first half of the year, nothing to add, and that's something which we already forecast.

Selling and general, a little bit [inaudible] but as you can see that we are down 0.9% in Q2. And we are also up 2.8 for the full first half. Definitely we thought that the promotional effort, as you could have imagined behind the four genericized products, so that is the main reason and I can confirm to you that on the other side, we are encountering now a stability in the G&A area that does translate for the first half in a reduction of G&A. But in increasing selling expenses, you can imagine that when we see increase, it's no increase -- no support at all from behind the generic product and the necessary support behind the other products and that's including the products which were lately launched as Hanspeter mentioned a little bit before.

That is the operating income current which, as you can see, is another improvement, and we can measure that, that the ratio to sales and other improvements at 0.9%. We are up to now 34.5% on sales, despite this generification and the fact that we support the R&D expense increasing this year.

Nothing to mention special from operating current to operating income on this quarter, and I am sure you will remember that the rest we had in the first quarter were mainly disposal of assets. Exubera being the most important, and as a second in importance being the remaining stake in the Animal Nutrition business. So operating income, at 5.4b.

Down, if we hit the page. On the financial expense side, it's a little bit heavier in the second quarter than it was in the first quarter. Now, this is not at all due to the interest charge of the company, but to the contrary. During the first quarter, we had a positive impact on financial instrument. I am talking of that financial derivative we had on the share of this company, the Australian company, CSL, following the sale of the Aventis [bearing] business. But so very positive impact during the first quarter and no impact during the second quarter. That explains to you the difference which you can see in the net financial expense during Q2 and H1. Nothing special to add to say on the tax rate.

And as far as these order line items, which is a share of profit and loss from associates, and minority interests, as you know, the most important components of these two line items are our association, alliance with Bristol-Myers Squibb on Plavix and Avapro and Aprovel. So this is increasing just because the products are increasing as already mentioned. In addition to that I have to mention as a substantial growth of that and net result of our 50% in Merial and we have 50% in that joint venture with Merck.

As we do usually, we give you some information on the impact of selected items during the period in order to better understand the level of preventability achieved during the period. Again, as you can see in this quarter, there is not much to mention, a negative impact of 6m, so I'd say already almost zero. So what we can read directly is that that second quarter came up with an adjusted EPS increase by 14.7% at 1.33, which translates, excluding selected items, at 1.34, up to 13.6% [sic - see press release].

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

If we now have the same kind of look at the end of the first half, well, as already mentioned, we had important positive selected items during the first quarter, mainly the disposal of assets, so there are two ways of reading the performance of the first quarter. The first one is to repeat the bottom line of the P&L, and that ends up with close to 4b of net profit, or 2.95 per share, up 33%. And if we look at that as usual, look at that excluding selected items, then we come up to 3.5b, 2.60 per share, up 16.1%.

As I'm sure you've seen from the press release, we've decided to upgrade our guidance following these good results as of the first half of the year. Instead of saying that for the full year we would achieve around 10% increase at the EPS level, barring any unforeseen major acquisition, despite the full year [at one], despite the generification, even that the launch costs of Plavix in Japan and Rimonaabant. Assuming that this is a technical one, which is very important, assuming 300m after tax level of selected items against 168m in 2005, and based on an exchange rate of \$1.25 per euro. Now, we are raising from around 10 to around 12.

I will probably develop, probably at that level, a little more understanding of how we could reap together. If I were to first come back to the original guidance, around 10 which is what I mentioned all year, we could also post it, as we did it together, saying that without selected items, that came up to around +8%. So what we are saying today again, without selected items, is around +10% at the EPS level.

You have seen that on the same basis, we've realized +16% at the end of the first half, I mean, without selected items. Now, in order to have a better reading, probably, of the first half performance, I have to remind you that first, as Hanspeter mentioned, the contract with the U.S. government in the sale of H5N1 was fully fulfilled during the first half, I mean \$150m or 120m. That won't happen again in the second half in addition to that.

Coming back on the synergies derived on the operational [side], you will remember that it's already said that we would have finished to deliver the synergies at the end of the first half of 2006, which is exactly the case. Again, you will remember that we said by the end of '05 that we will achieve on a cumulative basis, 1.4b before tax. We are now at 1.6 once again, an additional 200m before tax, which won't happen again during the second half. So I guess that these two items helped in decoding the performance of the first half, and in turn to understand what I've just tried to explain about the full year guidance.

If we go now to the statement of cash-flows, you can see that we had another reduction in the net debt position of the Group. We were at 9.9b net debt, December 31, '05. We are at 8.8. A good operating cash-flow before change in working capital, as compared to the first half of '05, and a little bit more burden on the side of the change in working capital, and I will give you probably two pieces of information in order for you to better understand why is it negative.

I guess that first, we have to compare these two periods for understanding this move. As you can see, it was almost flat last year, + 0.1b, and this is probably -- this is certainly this period in which there were some, I will not say, exceptional, but things to be noticed.

There are two items. The first one is the restructuring cost. As you will remember, we accumulated restructuring costs since August 20, 2004, and at the same time, we began to pay for this restructuring cost. During the first half of 2006, we only had a few [tens] of millions of additional restructuring cost, which by the way, drove us to a global, total accumulative amount, which is a little bit below 1.7b, which is to be compared to the original 2b that we guided you.

So we cannot accumulate very large restructuring costs, but at the same time, we paid a lot of restructuring costs. So you can see that last year, we had help in the -- if I may put it this way, in the change in working capital, because of this phenomenon, this first half and probably it's true for the rest of the world -- the year. We will have to pay for this restructuring, so a difference in balancing these two periods. In addition to that, you also know that for practical and technical reasons, you don't pay your income tax the year you book for it. You generally pay a year after. Well, we just have recently increased our net returns of the

FINAL TRANSCRIPT

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

company which you have seen I posted in 2004 and 2005. We are now, with one year delay, paying much more income tax than the previous year, and again, that explains something to you which is the difference in parent. Now, what I am saying to you, what I am trying to convey, is that -1.1 is certainly not something which is reproducible during the second half of the year at that level.

For the rest, acquisition of property, plant and equipment, 0.6, and intangibles, just to mention that there is a little something inside that 0.6 which is relating to the buyback of our write-off, Plavix and Rimonabant in Japan. The acquisition of consolidated investments, [Venteva], our 25% stake in that Czech company accounts for more than 430m, the rest being held by [Bacup]. The remaining 50% in a Japanese JV, which is selling a product whose name is [Ankaral]. This is [Aneodora].

Asset disposals, you know everything. It's mainly Exubera and [inaudible], the remaining stake disposal. Dividend, you knew that it was to be 2b, which was paid in June. So that does give you an explanation for free cash-flow of 1.1 during the first half, more or less, and 1.4 during the first half of last year. And well, I guess that we are around through for the presentation of the financial performance of the first half.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Thank you. Natalie, we can pass on to the question and answer session please.

QUESTIONS AND ANSWERS

Operator

[OPERATOR INSTRUCTIONS]. Our first question is coming from Tim Anderson with Prudential Securities. Please go ahead.

Tim Anderson - Prudential Securities - Analyst

Thank you, I have a couple of questions on Plavix and a couple on Acomplia. Plavix, can you theoretically submit a new revised settlement deal to the FTC or the State Attorney General, or is that not at all an option?

And then the second question on Plavix is, any sense for when you might go back to trials, seeing as discovery was wrapped up previously?

And then on Acomplia, I'm hoping you can say whether you've submitted a response to the approvable letter with FDA, and should we expect an advisory committee on this drug before the end of the year?

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

First I start with the Acomplia question. We have no information at all on an advisory committee. My understanding is that an advisory committee always could appear but to date we have not the slightest indication that the FDA does so.

Now, the second part of your question, we don't understand the ongoing process with the FDA, in the way that the FDA has written us a letter and we write a letter in return and then the file is settled. It is a permanent dialogue between the agency and us, where we submit information. The FDA may ask additional questions on the basis of what has been submitted. And this is a process which is going on in a very intense and regular manner, but this is not a, let's say, one time event. We send data and then we get an answer.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Jean-Claude Leroy - Sanofi-Aventis - CFO

As far as the Plavix question is concerned, it's done very well. Your interest surrounding the Plavix matter, that's the reason for which I will try to answer, or not to answer questions, but to give you the company's position on this Plavix matter so that we can afterwards pass on to any other questions.

As far as the litigation is concerned, to begin with. As we have previously disclosed our patent litigation in the U.S., against Apotex, was suspended due to the propel settlement. And as a result of propel settlements failure to obtain the clearance upon which it was conditioned, this U.S. patent litigation will resume. A new trial date has not yet been established. This will be done by the judge when he decides to do so. And in light of the current circumstances, I'm sure you will understand that we're not prepared to provide additional information at this time regarding these matters.

Now, I want to also give a word on the Department of Justice investigation, also in order to answer the question before I got it. We've learned that the anti-trust division of the United States Department of Justice is conducting a criminal investigation regarding the proposed settlement of the Plavix patent litigation with Apotex, and the Group has received Grand Jury subpoenas seeking the production of documents. Sanofi-Aventis intends to provide all the information required in response to this investigation. It is not possible at this time reasonably to assess the outcome of the investigation, or its impact on Sanofi-Aventis, and again, we will not comment any more pending the investigation. Sorry to be blunt on that subject, but I'd prefer to make a statement so that we can pass on something different. Any other question on any other matter.

Tim Anderson - Prudential Securities - Analyst

Okay, thank you.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Okay, next question please?

Operator

Thank you. Our next question is coming from Eric [Le Berigu] with Raymond James. Please go ahead.

Eric Le Berigu - Raymond James - Analyst

Yes, good morning, two questions on products. The first one on Ambien in the U.S. In the second quarter there is a very high growth of 58% in the U.S., which would seem to be significantly ahead of the prescription trends in the U.S. Could you say whether there is any stock effect there, or if the comparison basis was de-stocking in some extent last year?

The second question about your comment on Plavix in France and Germany, could you elaborate a little bit more about what is happening in France and Germany, and whether it's sustainable or perhaps a run-off in the second quarter?

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Well, on Ambien first, there are no changes in the stocks there. The stock of Ambien is stable for quarters and it is around 0.5, 0.6 per month. There are in fact some price increases in the U.S. We have followed overall a price policy very much in line with our competition.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

The competition has been priced very much ahead of us, and we have launched Ambien CR [at equal price with] Ambien [IR], so what we did in both quarters, 2006, we have increased prices of IR to a level that we are today nearly equally priced with [Lunessa]. I believe that they are now 2% or 3% only ahead of us. So you see this, but this is to my understanding the only effect which is worth to be mentioned.

On Plavix, what I tried to say was that we have today an environment especially in Germany where the total market and the prescribers are very much de-stabilized by those interventions, and we have seen more or less in the first quarter the same situation in France. And this has overshadowed, so to say, also the prescription of products which are not directly subject to those interventions, such as Plavix, which are relatively costly treatments, of course, and consequently always suffer. But in the underlying, how should I say, additives to the product and their prescriptions at the same time, there are no changes. They are just suffering, as Plavix has been suffering, to some extent, in both European markets by the restructurization of healthcare.

Eric Le Berigu - Raymond James - Analyst

Are you doing another price increase? You mentioned in the U.S. during the quarter?

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Yes, there are a number of price increases in the first quarter. We have made price adjustments in context with Allegra and Allegra [D]. There has been a price increase on Avapro, which is +4% which is net, substantially less because of the situation of the managed care and the competitive situation. And we have had a 4% price increase on Plavix in January and a further price increase also on [Actimel], [inaudible].

Eric Le Berigu - Raymond James - Analyst

Okay.

Operator

Thank you. We now move to [Amit Roy] with Citigroup. Please go ahead.

Amit Roy - Citigroup - Analyst

Hello, yes. Just three questions. Firstly, any update on the Dronedarone filing?

Secondly, regarding Lovenox, I recently heard that the Judge for the Lovenox trial has been changed, and clearly that's going to cause some delay. Any idea when we might be getting some sort of trial date coming on that?

And lastly, regarding Acomplia, the CV data you presented on the slide of focusing your promotional efforts on the cardiovascular coronary heart disease aspect of Acomplia, will you be promoting it for pure obesity, BMO of 30 any time soon? Thank you.

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Excuse me, I did phonetically not understand the end of your last question?

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Amit Roy - Citigroup - Analyst

Sorry. Regarding Acomplia, we can see that clearly, there's a high awareness for doctors to prescribe Acomplia in the U.K. and in Europe for the cardiovascular diabetic indication. Will you be promoting it heavily for the just pure obesity, no cardiovascular, no diabetic indication?

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

We start with the last question first, the answer is clearly no. We are strongly convinced that we don't have an obesity drug in front of us. And promotion for these patients would be frankly also not in line with the indication approved.

I indicated before that we are very happy with this indication because it perfectly reflects what has been undertaken in terms of clinical trial programs and which is the subject of our continued clinical research in this respect. So this clearly is the product for obese people, but having additional problems in the cardiovascular and in the metabolic field.

On Lovenox trial, I'm really regretful, but I cannot speculate on the trial date. We have an unfortunate experience that nothing is predictable in this respect. And the change of judges may have impacted in one or the other direction. But I think it would be useless to speculate on this.

Dronedarone, yes, the so-called action date is long behind us. We have received no substantial information at all from the FDA. Whenever we go back to the FDA you get relatively right answers, in the sense you will hear this in short. But this doesn't change anything. In essence, the action date has passed by and we haven't heard anything on this file which is regretful but, to a certain extent, reflecting the current situation of this agent.

Unidentified speaker

Thank you.

Operator

Thank you. We now move to Jo Walton with Lehman Brothers. Please go ahead.

Jo Walton - Lehman Brothers - Analyst

Good morning. Three quick questions please. Firstly, can you tell us, excuse me, a little bit more about what you expect to happen to the base business, the tail? You've seen a -7% decline in the second quarter. Can that all be explained by the, perhaps, one-time issues in France and Germany? And what do you think the outlook for that base business is?

Could you also tell us what the stocking level, what the one-time bolus sales into Japan were, if they were significant surrounding the launch?

And you've talked about the genericization of Eloxatine in Europe. You said you'd tell us a little bit more about that.

If I can chance my arm of a longer-term marketing question, you've managed to keep your marketing costs flat in the second quarter over the second quarter. What sort of rise in the overall marketing expense do you think we should expect to see in the second half as you ramp up your launch expenses for Acomplia?

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Yes, so to start with the base business, yes, good observation. Of course, minus 7.7% in the second quarter. What are the elements? First of all, there is a strong seasonal effect because this part of the portfolio contains the antibiotics. And it has been a very weak season, so to say, in Europe, but also abroad for antibiotics. So the first quarter has been weak.

Second, there is Ketek in this field. And, of course, there have been negative events you are aware of, which means that Ketek sales are depressed and did contribute.

If I take those effects out, and I take further out that there has been some generification effects, because [Avarine DDABP] are also subject to this definition of our portfolio, we have a net decrease between 2 and 3%, instead of those at 7 to 8%, which already is much more acceptable, so to say.

Nevertheless, I believe there is no alternative. And we have to continue to fight for this part of our portfolio which is about -- still about the state of our overall sales. And we will continue to do so for reasons which, I believe, are evident.

Nevertheless, you asked for a guidance. I believe that, to make a choice, that by the end this will remain to be a difficult year because this part of the portfolio has been struck by the interventions, especially in France.

And, well, it's very difficult to predict this part. We are confident that this has been a one-time event. In any case, it has been an event of a magnitude we have not seen in the French market before. And we very much hope that we will not see it again. But this is nothing but hope.

So I cannot give you much more of a precise guidance how this part of the portfolio will develop. But I am confident that the 7.7% you see in the second quarter will not be repeated. But this is paradox as it is. It is a very vulnerable part of the portfolio for interventions in terms of price reductions, the reimbursements and so on and so forth.

Now, on marketing costs, I would not say that we see a significant change in marketing costs in the remaining part of the year. There may be some impact from an Acompla launch in the United States. But this would be largely variable marketing costs and much less from fixed costs in marketing coming from people, because whatever is eventually needed in this respect is in place. So I don't see a significant change. Whatever may happen is perhaps about a percentage point or something like that.

On Eloxatine. Eloxatine, yes, we have indications that generic competition is coming up. There are notifications going on in Germany and in France and in the U.K. What we see so far is that those products are not ready-to-use formulations. They are the traditional powder forms which, of course, give us a certain advantage.

It is difficult to give you an exact date. But if something happens, it will happen towards the end of the year, in the fourth quarter, then eventually.

Is that satisfactory, Jo?

Jo Walton - Lehman Brothers - Analyst

The final question was just Plavix in Japan, whether there was a stocking effect?

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

The stocking, very insignificant. Really insignificant.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Jo Walton - *Lehman Brothers - Analyst*

Thank you.

Operator

We now move to Jerome Berthon with Aurel Leven Securities. Please go ahead.

Jerome Berthon - *Aurel Leven Securities - Analyst*

Yes. Good morning gentlemen. Just a few questions, if I may. With regards to the vaccine contract you talked about in Q2, have you got an idea about what could be the EPS growth related from this contract?

And also, just regarding an R&D update. Could we expect one before the end of the year?

And last but not least, with regards to this criminal investigation regarding Plavix, obviously, are you aware about a precedent in this kind of case and about the risk, just in theory, about the risk that you could face in terms of maybe negotiation with the government or fines? If you could elaborate a little bit.

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

Okay. So first, I already answer everything that concerned Plavix. I already delivered that, sorry. But I will stick to what I already said and I won't be able to answer to your question related to the criminal investigation.

As for us, the R&D update. Your question is we intend to do something during the second half of the year. No, we don't intend to do so just because of the fact that the result of the studies which are under current development won't be known, I think for some of them before the end of the year, or the very beginning of next year. And so, as we usually do each February, we intend to develop an update on the R&D portfolio situation at the same time we deliver the full-year results next mid February. That's the reason for which we won't -- we don't have the material to do so during the second part of the year.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

On H5N1, Jerome, we don't disclose profitability by product. But you can imagine that this is a commercial contract from the U.S. government, and we don't have a lot of promotional expenses behind this type of contract.

Jerome Berthon - *Aurel Leven Securities - Analyst*

Thank you.

Operator

The next question is coming from Michael Leacock with ABN Amro. Please go ahead.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Michael Leacock - *ABN Amro - Analyst*

Hi. I wonder if you can answer just a couple of questions. On the Eloxatine issue, could you be helpful and just give us some guidance as to the proportion of European sales in Eloxatine in those three countries of France, Germany and the U.K.?

On the H5N1 vaccine contract, could you give us perhaps some comment about the future contracts in terms of timing and scale for booking revenues from those?

And just briefly on -- the tax rate seemed quite low to me on the Q2. I may have missed it earlier on. But perhaps you could just comment on that for the full year '06 and going forward?

Hanspeter Spek - *Sanofi-Aventis - EVP, Pharmaceutical Operations*

Well, on the Eloxatine question, we don't give split of sales per product for, I think, understandable reasons. If I say those three markets, I can give you quite usual rate of share of those markets. It gives you a certain orientation.

I can nevertheless indicate that sense of Eloxatine in the United Kingdom are relatively small due to the effect that the product has been introduced relatively lately and has obtained reimbursement from NICE only recently.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

On H5N1, we have contracts pending in France, Italy and Australia. But it's not possible to predict the exact quarter in which the product will be applied and booked. Yes, it's also not of the same magnitude of the contracts that we had in the U.S.

Michael Leacock - *ABN Amro - Analyst*

Okay. Thank you.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Can we have the next question, Nathalie, please?

Operator

Of course. From Merrill Lynch, we will take our next question from Graham Perry. Please go ahead.

Graham Perry - *Merrill Lynch - Analyst*

Good morning. Thanks for taking my questions. I just wonder if you could give a little bit more detail on the Plavix slowdown in the second quarter of your consolidated sales. To what extent is that just pricing reforms and to what extent is that actually an impact on the volume growth. And can we expect the kind of growth rates that we saw in the second quarter to be what we should be looking for for the remainder of the year?

Then secondly, on Ambien, in the U.S., I think it looks as if the actual net price increase or list price increase is around 35% year on year. I was just wondering how much of that is actually coming to you net after rebates. Are you managing to capitalize on most of that?

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Thirdly, just an update on where you are with reimbursement discussions with Acomplia in the European territories you're intending to launch in.

And if I could ask you to repeat the comment, sorry, on the base business and your expectations for growth going forward in light of the European reforms. I'm sorry, you were breaking up at that point.

And then finally, just a straight-forward question on margins, if you assume Acomplia does get to the market and is being launched late this year, early next year, do you still think you could hold down your pharma margins at the kind of level that you're looking for this year? Thanks.

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

I think the last one is the easiest one. The answer is yes. It is the usual pictures that you have the largest investment for such a launch up front. So I would not expect any significant change in this respect for 2007 or later. We will launch this product over the next 24 months. And the major European countries will come this in the next nine months. And, as indicated before, hopefully also the U.S.

Well, you say then to repeat what I said on the base business. In simple terms, I said that this business is extremely vulnerable to government interventions, especially in Europe. I think I cannot go much further. I further added that we haven't seen this kind of traumatic intervention in France before. And therefore we are hopeful that this will not be repeated in the near future. But besides, I cannot make a lot of comments.

Finally, you have a business which is highly profitable and is representing a third of your sales. So you have to defend it. I admit this is all a little bit general. But I cannot be more specific for reasons which I hope are understandable.

Acomplia, the situation really varies from country to country. In the U.K., the reimbursement of Acomplia is today [suspended] until a revision by NICE. This revision will come. I cannot be precise when. But I would estimate it in the next 12 to 24 months.

In Germany, the reimbursement of Acomplia is [inaudible]. But without any doubt, Acomplia will become subject to the recently founded [ICVIC] Institution, which has a similar function as NICE. We believe that given the clinical importance of the product, ICVIC also will pick up Acomplia relatively fast. To give an estimate is impossible. This institution has just started to make the first revision.

In France, reimbursement is, so to say, up front. We have to negotiate this reimbursement before the launch, which means it is something which will happen during the next, let's say, six to nine months. And, of course, we believe that we have very good data to show the clinical benefit of the product and go ahead.

And so the situation varies really from market to market. I could add that in the Scandinavian markets which are subject to launch also in the next eight weeks, this product will be reimbursed from the very beginning. But as things are today in the pharmaceutical industry, you have to deliver first of all the necessary data to show the interest for public health service in Europe to continue to reimburse this and any other products.

Now, on Ambien. Frankly I am not prepared to give you the total price effect over the last 12 months. I believe it was lower than the figures you have indicated. But I think the real facts behind your question is what do we give to the healthcare providers in the U.S. Yes, we made concessions. In some respects that we made concessions to accelerate substitution of Ambien IR with Ambien CR. This is a process which is accelerating. And the strong boost that we have in our favor comes from the fact that we have six months more of protection from this product. So the healthcare providers, of course, have been a little bit reluctant to treat Ambien CR the same way as they have been handling Ambien IR before. We have put the necessary strategies in place. And what we see in terms of accelerated switch in the last weeks is largely due to this. We are approaching a situation where

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Ambien CR is more or less treated the same way than Ambien IR has been treated. And this has the desired effect. But I cannot give you much more as a general indication. You will understand that we are not ready to discover our rebate strategy in more detail.

Graham Perry - Merrill Lynch - Analyst

And on Plavix?

Sanjay Gupta - Sanofi-Aventis - Head of IR

Just wants to know guidance on Plavix [inaudible].

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Well, the guidance in Europe, 20. I cannot go much further than what I have said before. Yes, there is a difference of approximately 5 points in terms of growth between the second and the first quarter because in the first -- in the first half the growth has been about 14%, and in the second quarter the growth has been between 8 and 9%. Except before because that this is due to the overall climate in France and in Germany. Besides, we see a linear growth in the other European markets, like Italy and Spain. We have to see how the third quarter develops. But on the other side, you see you always have fluctuations between one quarter and the other. The second quarter has been relatively short in calendar days. Let's also keep in mind that this is a product of a size, that more and more the absolute growth becomes important than the relative growth. We feel there is nothing really of concern in Europe in terms of performance of Plavix, despite what we have commented so far for Germany.

Graham Perry - Merrill Lynch - Analyst

I guess the underlying basis of my question is are you seeing a slowdown in volume growth at all, or is this just pricing impact from the reforms? Or are the reforms actually affecting the volume?

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

No, we don't see a slowdown in volume growth.

Graham Perry - Merrill Lynch - Analyst

Okay. Thanks.

Operator

Thank you. [Ryan Bordeaux] with UBS has the next question.

Ryan Bordeaux - UBS - Analyst

Morning. A question -- or couple of questions related to seasonal influenza vaccine. You must have a reasonably good idea to find how about how many doses you'll deliver the season.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Excuse me, sir, we hear you very poorly.

Ryan Bordeaux - *UBS - Analyst*

I'm sorry, repeat please. You can't hear me very well? Is this better?

Hanspeter Spek - *Sanofi-Aventis - EVP, Pharmaceutical Operations*

It's a little bit better, yes.

Ryan Bordeaux - *UBS - Analyst*

Okay. I'll try and speak up. Just a couple of questions relating to seasonal influenza vaccine. You must have, by now, a reasonable idea of the number of doses you'll ship this season. Just wondering if anything -- if you see anything that might affect this. We have seen a couple of reports that one of the strains was lower yielding this season. Also you received a letter in the U.S. from the FDA. Is there any update on that and will that impact your deliveries this season? Do you have anything to say on this? Thank you.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Yes, Ryan, thank you. Essentially, the [inaudible] issue which were noted in the FDA letter were at a very early stage. It was at the mono [inaudible] strain stage, so the strains had not yet been combined to make the trial [impacting]. Because of which it is not going to impact the production for this year. So we are pretty confident of supplying our commitment of around 50m doses of influenza vaccine for the U.S. market in the 2006/2007 stage.

Ryan Bordeaux - *UBS - Analyst*

Thank you.

Operator

We now move to Peter Dullmann with Oppenheim. Please go ahead.

Peter Dullmann - *Sal Oppenheim - Analyst*

Yes. Peter Dullmann, Sal Oppenheim. Good morning to you. One question, coming back to Germany. I assume that you're also not willing to comment on German Plavix figures. Maybe you can give us a general comment on what's going within the already-mentioned ICVIC Institute which is currently reviewing the reimbursement status of Plavix.

And the second question, selected items for the first half. You mentioned 460m, if I remember that correctly. For the full year, you're going for 300m within your guidance. Which kind of negative selected item impact are you expecting to occur in the second half? Thank you very much.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - *Sanofi-Aventis - EVP, Pharmaceutical Operations*

So, on ICVIC first. The overall activity so far as ICVIC is concerned, and is concerned for the total industry. And the industry has expressed itself, the industry feels that ICVIC, in contrary to, for example, NICE, is not working independently. We feel that ICVIC is evaluating information in a highly selective way which we and other major companies continue to criticize.

And this criticism became very, very obvious during the recently published position of ICVIC on the short-acting insulin. And there we are totally in line with the criticism expressed by Lilly and Novo Nordisk. And we are evaluating our positions in this respect, including legal opportunities or options we may follow.

It is correct what you mentioned that ICVIC currently is working on an evaluation of Plavix. This is the use of Plavix in the field of PAD, in comparison with Aspirin. We are contributing to this evaluation. The evaluation is pending. I am not aware of when this evaluation will come to an end. We look to assist this. There is some scepticism of course coming from the recent publication of the short-acting insulin. But it's too early to say. We don't know what is coming out.

Jean-Claude Leroy - *Sanofi-Aventis - CFO*

As far as your question on the selected items is concerned, and as for the guidance. You are right in saying that at the end of the first half we have a net impact of 460m of selected items. I have several comments to try and answer your question.

As I already mentioned in our conference call, these kind of items are mainly unpredictable. I mean by that that we don't have the agenda, as you understand. This was all of a sense making either capital gain or capital loss. So we cannot predict. At the same token, we are not capable of predicting the impact and the variation of the stock exchange on some participation which we do have on some listed companies. I am talking of Biotec. I cannot either predict about the impact of the financial instrument type, like I said earlier in the year on the [CSL] matter.

So the exact answer to what is the predictable evolution of that 460m for the end of the year? We don't know. That's the reason for which when we posted the first guidance of the year and when we are posting today our revised guidance, we are saying -- we are expressing the potential evolution of the EPS, given certain definite number in euros of selected items.

In other words, this is purely a help for you to make the calculations. And that's the reason for which also I try to give another help to the reading by saying that, yes, at the beginning of the year we anticipated a growth, without selected items, by 8%. Today, we are raising our guidance at a 10% level without selected items.

In other words, what I am trying to convey is that when we said that we anticipate around 10% without selected items, I guess that you have the information which is necessary to anticipate from the bottom line. Except for selected items which, this is true, are adding up to 460m at the end of the first half. I cannot predict exactly what they could be, what they are going to be plus or less.

At the end of the year, when you have the results of a litigation, and you had a reserve by [inaudible], you will discover that it's going to be plus to your P&L or minus to the P&L. It's very unpredictable. And that's the reason for which we offer you to try and think without selected items. Even so, this process exist. But we are not capable of giving you any reasonable prediction on this item for the rest of the year.

Peter Dullmann - *Sal Oppenheim - Analyst*

Thank you very much.

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Sanjay Gupta - Sanofi-Aventis - Head of IR

Nathalie, maybe we have time for one last question.

Operator

Okay. Our last question is coming from Kiyoshi Ando from the company Nikkei.

Kiyoshi Ando - Nikkei - Analyst

Good morning. This is Kiyoshi Ando of Nikkei Newspaper. I have a question concerning Japanese market. You said Plavix is very insignificant in Japan. But does this mean that it's well below your expectation? How is it doing if you compare it with what you have expected?

And secondly, about Rimbonabant, you have taken back your license now from [inaudible] Sanofi-Aventis, I believe. How much are you willing to invest for the marketing of this drug in Japan? And will you need additional sales forces for that? Thank you.

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Yes, thank you for those questions, also because I think I have not been precise enough on Plavix. I understood the question from Jo Walton in the sense that if these so-called wholesaler stocking would have been significant in Japan, and in this respect my answer was no, not significant.

The way the Japanese market works makes it that wholesalers' stock up in front of introductions are not very important because you have to get approval hospital by hospital. So the entry into market is relatively slow. So I didn't want at all to indicate that Plavix overall would be insignificant. It is, in fact, too short in terms of launch to make a clear statement on the sell out, which means the reaction to the product in terms of real demand. But once again, my comment was just on the wholesaler building up stock effect.

Kiyoshi Ando - Nikkei - Analyst

So your goal of selling this year's objective remains the same?

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Yes. It's totally unchanged, of course. Totally unchanged.

Now, on Rimbonabant, you see, it's a little bit early to make a prediction how much we will invest in terms of launch because the launch of Rimbonabant in Japan is some years away. We have taken back this product in order to better manage the clinical development of the compound in Japan, which is ongoing.

But we are, as you say, at the end of phase II B. And we will enter 2007 in phase III. So we have to continue to invest in the clinical development. And then we will do whatever is needed to make this product a success in terms of the adequate marketing investment, as you are right, in let's say, 2009 or 2010.

Kiyoshi Ando - Nikkei - Analyst

Thank you.

FINAL TRANSCRIPT

Aug. 02. 2006 / 2:00AM, SNY - Q2 2006 Sanofi-Aventis Earnings Conference Call

Sanjay Gupta - Sanofi-Aventis - Head of IR

Okay. With that, we come to the end of the conference call. Thank you for assisting. And if you have any further questions, please don't hesitate to call Media Relations or Investor Relations. Thank you.

Operator

Ladies and gentlemen, that will conclude today's conference call. We thank you for your participation. You may now disconnect.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2006, Thomson Financial. All Rights Reserved.

Exhibit T



sanofi aventis

Because health matters

THE LANCET PUBLISHES RIO-DIABETES STUDY¹

- Study Shows Rimonabant Significantly Improves Weight, Blood Sugar Levels and Other Cardiometabolic Risk Factors in People with Type 2 Diabetes -

Paris, France, October 27th, 2006 – Sanofi-aventis announced today that the results of the RIO-Diabetes trial were posted on *The Lancet* online edition (publication in the print edition is expected shortly). The one-year trial showed that rimonabant 20 mg once daily significantly improved several cardiometabolic risk factors including weight, HbA1c (a measure of blood sugar control), HDL-cholesterol (good cholesterol) and triglycerides (fats in the blood), systolic blood pressure as well as waist circumference (a marker of intra-abdominal adiposity) in overweight / obese patients with type 2 diabetes uncontrolled with metformin or sulfonylurea. Importantly, over 50% of the improvements in HbA1c and HDL-cholesterol were independent of the weight loss achieved, suggesting a direct effect of rimonabant on these parameters.

“The RIO-Diabetes study showed that rimonabant 20mg significantly improved weight, levels of blood sugar and other cardiometabolic risk factors important in the management of type 2 diabetes,” said Professor André Scheen, Head of the Clinical Pharmacology, Division of Diabetes, Nutrition and Metabolic Disorders, Academic Hospital of Liège, University of Liège, Belgium, principal investigator of the RIO-Diabetes study and a member of the RIO programme steering committee. *“The improved blood sugar control plus weight loss achieved with rimonabant is very encouraging. Today, most medications for type 2 diabetes are associated with weight gain and it is difficult for people with diabetes to lose weight and keep it off.”*

Among all patients who entered the RIO-Diabetes study, patients on rimonabant 20 mg once daily achieved an HbA1c reduction of 0.6% versus an increase of 0.1% on placebo from a baseline value of 7.3% and 7.2% respectively ($p < 0.0001$ vs. placebo). Among those patients with a higher HbA1c ($> 8\%$), rimonabant 20mg once daily achieved a reduction of 1.1%, compared with a reduction of 0.3% in the placebo group. Nearly 70% of patients treated with rimonabant 20 mg once daily lowered their HbA1c levels to below 7% as compared to only 48% of patients in the placebo arm ($p < 0.0001$). Even more impressive, 43% of patients on rimonabant 20 mg once daily had HbA1c levels $< 6.5\%$ at their final visit compared to only 21% in the placebo group ($p < 0.0001$). Approximately 57% of the reduction in HbA1c levels achieved with rimonabant 20 mg once daily was calculated to be independent of the weight loss achieved. The direct peripheral metabolic effects of rimonabant on other cardiometabolic risk factors has been demonstrated throughout the RIO clinical trial programme.^{2,3,4}

“What is so significant about these findings is that rimonabant was able to reduce blood sugar levels in a patient population where further control or lowering is often difficult to attain. This is very important because for every 1% reduction in HbA1c there is an associated reduction of risk of 21% for any endpoint related to diabetes⁵” said Professor Scheen.

Press Release



sanofi aventis

Because health matters

Patients treated with rimonabant 20 mg once daily benefited from a reduction in weight of 5.3 kg (11.7 lbs) versus 1.4 kg (3 lbs) for patients in the placebo group ($p < 0.001$ vs. placebo). Waist circumference was reduced by 5.2 cm (2.05 in) in patients in the rimonabant 20 mg group versus 1.9 cm (0.7 in) observed in the placebo group ($p < 0.001$).

HDL-cholesterol and levels of triglycerides were significantly improved in patients treated with rimonabant 20 mg once daily throughout the one-year period. Among all patients who entered the study, HDL-cholesterol increased by 15.4% in the rimonabant 20 mg once daily group versus 7.1% in the placebo group ($p < 0.0001$). Furthermore, levels of triglycerides were reduced by 9.1% in patients treated with rimonabant 20 mg once daily compared to an increase of 7.3% in the placebo group ($p < 0.0001$ vs. placebo). Approximately 57% of the increase in HDL-cholesterol achieved was not explained by weight loss alone and considered to be due to the direct effect of rimonabant ($p < 0.0001$).

Rimonabant is the first selective CB1 receptor blocker which helps to reduce overactivity of the newly characterized endocannabinoid system (ECS). CB1 receptors, which form part of the ECS are located centrally in the brain, and peripherally in adipose tissue, liver, skeletal muscle, pancreas and the gastrointestinal tract. The ECS has been shown to play an important role in energy balance as well as being directly involved in fat and sugar metabolism.⁶ Peripherally, overactivation of the endocannabinoid system promotes fat accumulation at the level of adipose tissue and decreases glucose uptake in skeletal muscle; this can lead to increased risk of development of insulin resistance and impaired glucose tolerance. By blocking CB1 receptors in the brain and peripheral tissues, rimonabant results in a decrease in food intake, a loss of body weight, and direct improvements in cardiometabolic risk factors, such as blood sugars, HDL-cholesterol and triglycerides.

The RIO-Diabetes study also assessed the safety and tolerability of rimonabant 20 mg once daily, 5 mg once daily and placebo, the results of which were consistent with the data from the entire RIO clinical trial programme which involved more than 6,600 patients. Side effects were mainly mild, transient, self-limiting and occurred early in the treatment period. The most frequent side effects included nausea (12.1% for rimonabant 20 mg once daily vs. 5.7% for placebo), dizziness (9.1% for rimonabant 20 mg once daily vs. 4.9% for placebo), diarrhoea (7.4% for rimonabant 20 mg once daily vs. 6.6% for placebo), vomiting (5.9% for rimonabant 20 mg once daily vs. 2.3% for placebo), self-reported hypoglycaemia (5.3% for rimonabant 20 mg once daily vs. 1.7% for placebo), fatigue (5.3% for rimonabant 20 mg once daily vs. 3.7% for placebo) and anxiety (5.0% for rimonabant 20 mg once daily vs. 2.6% for placebo). Discontinuation rates due to adverse events were consistent with those reported in other trials in the RIO programme (15% for rimonabant 20 mg once daily vs. 5% for placebo, $p < 0.005$). The most frequent adverse events leading to discontinuation were depressed mood disorders, nausea and dizziness.

Sanofi-aventis received an approvable letter for rimonabant from the U.S. Food and Drug Administration (FDA) in February, 2006. In Europe, rimonabant, known as ACOMPLIA® is approved as an adjunct to diet and exercise for the treatment of obese patients ($\text{BMI} \geq 30 \text{ kg/m}^2$), or overweight patients ($\text{BMI} > 27 \text{ kg/m}^2$) with associated risk factors, such as type 2 diabetes or dyslipidemia.

Release



About the RIO-Diabetes Trial

RIO-Diabetes is a phase III, multinational, multi-centre, randomised, double-blind and placebo-controlled trial which compared two fixed-dose regimens of rimonabant (5 mg once daily and 20 mg once daily) to placebo for a period of one year. The study was conducted in 1,047 people with type 2 diabetes at 159 centres in 11 countries. Study participants were male and female aged between 18 and 70 years of age and had a BMI of between 27 kg/m² and 40 kg/m². Additional criteria included an HbA1c level between 6.5% and 10% and a fasting blood glucose level of between 5.5 mmol/L (100 mg/dL) and 14.9 mmol/L (270 mg/dL).

The objectives of the trial were to assess the efficacy and safety of rimonabant in patients with type 2 diabetes already being treated with either metformin or sulfonylurea monotherapy. The study investigated the effect of rimonabant on HbA1c, and other cardiometabolic risk factors. Safety and tolerability were also evaluated over the one-year treatment period.

The RIO-Diabetes trial is one of four phase III studies comprising the RIO programme, which assessed the efficacy and safety of rimonabant in cardiometabolic risk factor improvement and weight loss in over 6,600 overweight and obese patients studied worldwide. All four trials - RIO-Diabetes, RIO-Lipids, RIO-Europe and RIO-North America - in the phase III programme have been completed.

The results of the RIO-Diabetes trial were first presented at the Annual Scientific Session of the American Diabetes Association in June 2005.

About sanofi-aventis

Sanofi-aventis is the world's third largest pharmaceutical company, ranking number one in Europe. Backed by a world-class R&D organization, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine, and vaccines. Sanofi-aventis is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expects," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.



Media Contact:

Nazira Amra +33 (0) 630 32 63 15

¹ Scheen et al. Effect and tolerability of rimonabant in overweight or obese patients with type 2 diabetes : a randomised controlled study. ; www.thelancet.com

² Van Gaal et al. Effects of the cannabinoid-1 receptor blocker rimonabant on weight reduction and cardiovascular risk factors in overweight patients: 1-year experience from the RIO-Europe study. Lancet. 2005 Apr 16-22;365(9468): 1389-97

³ Despres J-P., Golay A., Sjostrom L., for the RIO-Europe study group. Effects of rimonabant on metabolic risk factors in overweight patients with dyslipidemia. New Engl J Med 2005, 353.2121-34.

⁴ Pi-Sunyer, X et al. Effect of Rimonabant, a Cannabinoid-1 Receptor Blocker, on Weight and Cardiometabolic Risk Factors in Overweight or Obese Patients RIO-North America. A Randomized Controlled Trial. JAMA, February 15, 2006 ;Vol 295, (7): 761-775

⁵ Stratton IM, Adler AI, Neil HA, Matthews DR, Manley SE, Cull CA, Hadden D, Turner RC, Holman RR. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. BMJ 2000;321(7258):405-12

⁶ Di Marzo V, Matias I. Endocannabinoid control of food intake and energy balance. Nat Neurosci. 2005 8:585-9

Press Release



Exhibit U

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Event Date/Time: Oct. 31. 2006 / 2:00AM ET

FINAL TRANSCRIPT

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

CORPORATE PARTICIPANTS

Sanjay Gupta

Sanofi Aventis - VP, IR

Hanspeter Spek

Sanofi Aventis - EVP, Pharmaceutical Operations

Jean-Claude Leroy

Sanofi Aventis - EVP & CFO

CONFERENCE CALL PARTICIPANTS

Matthew Weston

Lehman Brothers - Analyst

Graham Parry

Merrill Lynch - Analyst

Andrew Baum

Morgan Stanley - Analyst

Phillipe Lanone

CDC IXIS Capital Markets - Analyst

Sebastien Berthon

Exane BNP Paribas - Analyst

John Murphy

Goldman Sachs - Analyst

Tim Anderson

Prudential Equity Group - Analyst

Ben Yo

Dresdner Kleinwort - Analyst

Stuart Close

HSBC - Analyst

Amit Roy

Citigroup - Analyst

Michael Leacock

ABN AMRO - Analyst

Alexandra Hauber

Bear, Stearns - Analyst

Paul Mann

Deutsche Bank - Analyst

PRESENTATION

Sanjay Gupta - *Sanofi Aventis - VP, IR*

Good morning and many thanks for joining us. I would just like to clarify we are presenting third quarter results. I'm joined today by Mr. Hanspeter Spek, our Head of Operations, Mr. Leroy, our Chief Financial Officer, and [Lauren de Brue], our [inaudible] CFO.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

During this conference call we may make projections and forward looking statements that are based on management's current expectations, but actual results may differ materially due to various factors. For additional information about the factors that affect our business, kindly refer to our forward looking statement on slide two as well as our 20-F.

The format of today's call will be a short presentation followed by a Q&A. Mr. Spek will comment on the business during the quarter. Mr. Spek.

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Thank you Sanjay. Good morning. So I thank first of all that you are being with us so early at least in Europe today. We will try to explain the background of our results of the third quarter to you, and I propose that we go to the slide pack which has been sent to you. And start there with page number three.

Now, the comments on this quarter are difficult because without any doubt this has been a less successful quarter for our Company, than any quarters before. Nevertheless, there are three major issues which have influenced this quarter and our performance within. The first one we have seen heavy traffic, crucial even interventions in certain European markets, especially in France and in Germany but not only. Second there has been, of course, the chain of events around Plavix and Apotex in the United States. And third, we are at the end of the period which started nine months ago in the United States, and four of our products in the United States went off patent. The most important one was Allegra.

So the last one is, of course, an event which comes to its end and this is, of course, one of the elements which makes up carefully optimistic for the upcoming, or better said, ongoing fourth quarter. The two other events, of course, does maintain.

So if you look to this chart, you see then that there is a negative growth in this third quarter of 1.1% in terms of sales. And you see that this is also due to the vaccine business, which has been showing a very strong, even two digit growth during this year, minus 7% for the third quarter. Which is another fact, we will go back to it in more detail, but I can indicate already now that this is a technical effect, coming from circumstances around the production and putting on the market of flu vaccines. As all other providers, the deliveries have been delayed, retarded, but a lot of sales will be completely recovered during the fourth quarter.

If you look into the geographical split you see that, yes, there is a negative figure for Europe of minus 2%. The European figure, of course, contains the events just described for France and Germany. You see minus 5% in the U.S. This has nothing to do with targets. We are talking about consolidated sales. So this is largely the effect from those four products going off patent in second half of 2005. And, yes, last but not least, you see that our growth in the so-called rest of the world is being maintained with more than 8% as compared to 9.9% in the nine month period of 2006.

Last word on the so-called base business. You see that there has been a little improvement from 5.4% minus to 4.3%. We are relatively content with this development keeping in mind that, of course, the base business is first of all struck by all those interventions, as those taken place in France like price cuts and the reimbursement. Also a third of the base business is equally struck by the out of patent situations in 2006. So if you would take those events out, the negative growth is minus 2% to minus 3%, which we feel is not too bad given the circumstances.

On the next page, page number four, you see then the performance in detail for the top 15 products. You see that Lovenox just missed the two digit growth with 9.2%. You see only 2.5% of growth in consolidated terms for Plavix. And here please keep in mind that in the consolidated sales, included are our sales for finished product of Plavix to our partner, Bristol Myers Squibb, in the United States.

You can correct this and you come up to a figure of an additional growth of 5% to 6%, because those sales have been missing consequent to the Apotex event in the United States. You see then further in extremely strong and very healthy growth of

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Stilnox, Ambien and Ambien CR. I get back to this in some more detail. And you see a certain [demote] in Taxotere, only 5% growth which, and I would also clearly like to come back to this in an instant, is due to an absolute continuous unsatisfactory performance of Taxotere in the United States. Outside, Taxotere continues to do well. Then Eloxatin, we see the first impact of upcoming generic competition in Europe whilst the product, of course, remains protected in the United States.

So if you look to the top 15, you see a growth of 1.5% as compared to 5% for the nine month period. But, once again, please keep in mind the additional growth of approximately 5% to 6% for Plavix, due to some events.

Now on a more geographical basis as from page number five. Here you see our performance in the United States, as compared with the market. You see first of all on the right side of the page, that the American market will certainly expand, is in the process of coming back from growth rates on the level of 5% to 8%, 9% during the recent months. And you see that also see Sanofi-Aventis's performance is taking advantage of this comeback. And you see, of course, that the performance is well above the market average, when excluding those four products which went out of patent in the second half of 2005.

On the next page, page number six, you see the real issue we have had to face in Europe. First of all in France and Germany, but please keep in mind that we have also seen price reductions in Portugal quite recently, and also in Italy.

Now back to France. You see that the growth of the market is close to zero, and you see that we are performing under the market, which is largely due to the fact that we are extremely exposed in France with a market share of approximately 18%. And those measures, as outlined on the left side of the page, have had a severe and significant impact on our volume.

In Germany the events took place a little bit delayed as compared with France. Nevertheless, you see basically for the market the same trend. The trend of the market has been before artificially inflated. In the first half of 2006 we saw a very strong stocking. You may remember that the French government took some measures, which went into the direction of forbidding price reductions and discounts for generic products to pharmacists. This led to an overstocking in the first half, but afterwards the market became significantly negative. The only positive mentioning perhaps, the fact that our performance is closer to the market, perhaps due to the fact that our exposure is less important in Germany. But nevertheless, also in Germany we are currently number two of the pharmaceutical market.

How did we address those situations in the free market I have commented so far? Yes, we have just buy it and the necessary cost cutting. This is true for variable parts and Jean-Claude to comment, then he makes an instant more explanation on our profit and loss. And also by social measures, those have been reflected partially in the international press since the last two days.

The fact is that we are in all three countries in a very intense, but also absolutely constructive style of this our social partners, to make the necessary adjustments. In average you see that in Germany and in France our negative growth is approximately 10% and we are going, of course, in this direction as far as cost cutting is concerned.

On page seven you see then on the left side first of all the performance in Europe. Then excluding France and Germany, it is good to see that in those markets which are not struck or less struck by government interventions, our performance is despite the fact that we are market leaders is still very well above the performance of the market. And yes, as indicated before, this is even more for the so-called rest of the world, intercontinental region and Asia Pacific, where our performance is well above, despite the fact that we are market leaders, within those segments of the world market. Also called the [inaudible] market.

Now on page eight you see the performance of Plavix, and perhaps that's the opportunity to give you a little bit more insight on the circumstances. What can we say? We can first of all not say what we see, current stock of clopidogrel in the American channel. You may believe that we make a significant effort to get estimates. This is extremely difficult because Apotex has concluded that secrecy and confidentiality agreement, when delivering its partners in the trade. Consequently, those partners are still bound to certain agreements and have to refuse to give us precise information. That's one of the effects which makes

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

it extremely difficult for us to commit to Plavix sales until the end of the year and even into 2007, because we have a very, very limited visibility.

The second fact we do know is that the sales in terms of product which is being expensed following a clopidogrel prescription are partially coming back. The last figures I had for the slide here are 30%, 32%. So we can say that the share of Plavix inside the total molecule prescription is improving every week between one and two points. Of course, this is nothing but an indicator, but nevertheless it's an encouraging one.

Related question, what happens with managed care? Yes, according to the mechanics which are in place in the managed market, we have lost a number of favorable tier ratings. Which means we have today in a number of accounts ratings which are inferior to the previous one. Also, this is an issue which is extremely difficult to predict. It is clear that we are fighting, arguing and negotiating with our partners in the trade and on the payers' side, in order to improve those. But those negotiations are difficult and not very substantial, as long as there is substantial stock in the trade. But we are, of course, convinced that we will gain visibility also in this respect, day after day, week after week, as more as the Apotex will be exhausted.

Now what is the bad news in this context that result? The fact that the clopidogrel molecule total prescription remains on a very, very good level of approximately 15%. If you look to the curve, you may even see a little acceleration at least, this the beginning of this year. Which partially maybe due to the fact that we have gained an additional indication, a [stimulate] indication, during all those turbulences and the anticipation of the question of course. During all those turbulences we have continued to promote and to advertise this product, and we have even accelerated also with the -- this effect for -- to accelerate ending the stock of Apotex's product in the trade. I think that the only comment I can add, more on Plavix concerns.

In Europe you see a relatively modest growth rate of 7%, 7.5%, which is largely due to the situation in Germany and France. Where we have seen heavy interventions on the product in terms of prescribing instructions in Germany, in terms of price cut in France. We believe that this is another after effect of this little bit unfortunate third quarter. And we will go back to a more normal pattern during the fourth quarter.

Now one word on Plavix launch in Japan. You know that the product has been launched during the second quarter 2006. The Japanese situation, allow me to say as usual, is a little bit different from the rest of the world. When launching Plavix in Japan we are being faced with two hurdles. The first one is that we cannot advertise the product to all potential prescribers because there is a so-called [cross] marketing vigilance period in place. Which means we are obliged to call on a limited list of subscribers, and we have to call on those subscribers in a very high frequency. Which means every second week we have to call on those subscribers, and to monitor it for eventual safety issues. Which, by the way, we did not detect, at least we didn't detect anything surprisingly.

Nevertheless, this is an important limitation and the other one exactly is the same. A limitation until May 1 2007 in place concerning the fact that a prescribing doctor can prescribe only two weeks of treatment. This, of course, obliges the patient to come back every two weeks, which is highly inconvenient, but in order to bring this product in a very controlled way to the market, probably adequate.

As a consequence in recent launches, and you see the same on the right page of the chart. You see that all big products have had a very slow penetration for the first six, eight months in the Japanese market. And you see the red lines for Plavix is perfectly in line with those the penetration patterns.

Optimistic indicator below to how you intend to prescribe. You see that the intention to prescribe is between 55% and nearly 70%. And, of course, you see also a significant difference between the intention of neurologists and the intention of GPs due to the fact that this product is today registered and approved in stroke.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Now on Acomplia, we have launched in Germany, Denmark, Finland, Norway, Austria, Ireland and Argentina. We have small sale of 11m in the third quarter which is not at all a surprise because the launches took place just this quarter. And in most of the markets we only launched in the last month, in September.

First some information on U.K. U.K. has been the first launch of those European launches. We have a very good references and benchmarks, and you see that the Acomplia launch is doing well. Allow me to say even very well because we are on a level of Nexium and Seretide. And are getting close to [Crestor], the penetration is much stronger than Lipitor had at the same point of launch. And once again, is also at the same or far better even than the penetration we had with Plavix two or three months post launch.

We monitor this launch as any other with a lot of intention -- attention as you see on page 11. We are very much control the targeting of doctors in order of course come to the right patient. And you see that the diabetologists by far meets the group of physicians intending to prescribe the product, and then followed by the cardiology. Due only followed by the GPs. We see this a s a very encouraging sign, in order to measure that this product is getting adequately medicalized with this positioning.

You see further that this trend placed into the right patients. Because the vast majority of those patients is not only overweight or obese. No, the vast majority, let's say 80% approximately, have associated with this obesity, with this overweight status other problems in the field of cardiometabolic problem.

The same picture in Germany then on page 12. In Germany we have very little data so far because the product has been launched only at the beginning of September. Nevertheless, you see once again, as I said, cardiologists and diabetologists are in the lead. And you see also that there is once again a very, very high interest to prescribe this product, above 80% for all those target groups.

And you see that once again we are targeting and the physicians are targeting the right patients, which means the patient with associated further risk factors. And you see once again that purely only, so to say, obese patients represent less than 20%.

Now a word on the German launch. I -- for reasons you will understand, I cannot give you a precise sales figure, but I think it's fair to say that the success has been extremely successful so far in Germany in terms of all the economic reaction to our promotion in the first month of September. And this continues of course into month of October.

It is no surprise that this has caused concern from the German authorities, as far as the economic consequences are -- have been concerned. We have signaled a significant amount of understanding, and we have made proposals to the German authorities of limiting voluntarily the target patient. Unfortunately, those proposals have been not so far accepted.

You are potentially aware that the GBA, which is the institution of those physicians associated to the public sick fund has given a recommendation to de-reimburse the product. And this is something awaiting the approval or the disapproval of the German Health Minister, as the Health Minister normally has two months to decide. And we are at the beginning of this period.

You may understand that I would not intend to go much deeper into this, but saying that we continue to argue, to explain. And, of course, we are also getting more and more references out of the European community. And, yes, we are to a certain extent proud to be able to announce that the product quite recently has been reimbursed in Ireland and in Denmark. Denmark traditionally a very critical market for reimbursement issues. And I can tell you that the decision on reimbursement in Sweden is imminent, as is [inaudible].

Associated with our argument, we continue to exercise in Germany and elsewhere in Europe. You find then on page number 13, a summary of the methodology of the so-called Serenade study. This is a key study for the first lifecycle management of Acomplia. Why? Because it's the first study in treatment naive patients suffering a type 2 diabetes. You see that it is, of course, a comparative study against placebo and is, of course, randomized. And this study will be presented at the international congress

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

in December 2006. And it is clear, in fact why we put it into this presentation, that we are looking forward to those presentations of the final results of this study. As you say, a lot of optimism and also confidence.

Now on page number 14, a word on Ambien. First of all, you see on the left side of the chart a very, very significant acceleration of this important product in the United States. You see then the family is growing by 21% in August, going -- coming from 16% last year. The product has been burdened by a negative publicity during the first half, which caused a certain slowdown in growth. We have not only recovered this we have further accelerated, I believe, basically by the advantages of Ambien CR. Which meanwhile also overtook [inaudible] in terms of total prescriptions, which were not certainly evident at the beginning of the year. In fact, [inaudible] of course we continued to invest in this product, and the results are there.

Key target still is to switch as many patients as possible from Ambien IR to Ambien CR. In this respect, we have filed for a prolongation of patent protection. This has been done in time by September 29. And now the approval of the FDA in this respect is imminent. As long as this approval is not being prevented, generic cannot come to the market as you very well know.

We have announced, I would say two years ago approximately, a target of 50% switch. You see on the chart that as of the second week of October, the switch rate has been 31%. We are gaining per week approximately 1% to 2%, which means we are still very confident and optimistic. With the six additional months of data protection for Ambien, to get very close to the peers in the marketing. Which, as you see, that we are today more or less on the level of [Paxil]. And, yes, Nexium remains our main benchmark, and we continue to work into this direction.

On page 15, then [outlook] on Lantus. Lantus continues with nearly two digit -- excuse me, Lovenox continues to grow nearly two digits. The -- perhaps most important use is that we see a very strong acceleration in the U.S. retail demand, outlined on the right side of the chart. This is important because it is important for the patient. The patients are being longer treated which means they are being better protected. Yes, and economically it is equally very important because the price level in the retail sector is superior and, consequently, of course, our margin.

On page 16 then, the success story of Lantus continues. You see it's 31% growth. You see that on the right side that at the middle of this year Lantus became the leader of the total U.S. insulin market. In terms of total prescription, you see that most of the other product are going either down, also show only a very, very marginal inroad into this insulin market, as you see on the lower right side of the chart.

On page 17, you see our new pen, SolaStar. This is a pen which has been developed in-house. We have made significant investment to do so in our factory in Frankfurt. This is a new pen for us. We believe that it is on a top level in terms of utility. We start to launch this new pen as of now. The pen has received approval from the European authorities. In the United States the request for approval is under revision. And we will be starting to launch this product, potentially for us before the end of the year in Australia, where we are doing today an intense program of testing and pre-marketing. And then consequently during 2007 in all other markets and also, of course, in the United States.

To anticipate perhaps a question, we don't see this product in competition with our major supplier. It's -- for me it's a product is in contrary to the [inaudible] product, a disposable pen. So we see there's a complementary strategy and not as a replacement.

On page 18, now I have indicated this before. We still have the unsatisfactory picture of Taxotere in the United States, which is contrasted by 11% roughly 7% growth in Europe and the rest of the world. We continue to work on our U.S. organization in this respect. With some reason, we have nevertheless to admit to that. As you see on the right side of the chart, that the product has obtained significant penetration in a number of its indications in the United States.

So naturally penetration is getting more and more difficult. Nevertheless, it is to date the only [metastatic] agent which is being indicated in five different indications, a fifth with the quite recent approval in head and neck in the United States, and outside. So, yes, you will continue to fight for this product also in the United States.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

On page 19 there is a word on Eloxatin. I have indicated before that in Europe we are now approaching the fact that the product goes off pattern, and we see the first generic entries, especially in Scandinavia. And, of course, those entries are imminent during the next months also on continental Europe.

We try to counteract this with two lifecycle management strategies. We have launched worldwide the aqueous formulation. In nearly all of those markets, the aqueous formulation has replaced the [inaudible] which was the original form. This aqueous formulation represents a number of safety issues, especially for those people who have to work with the product in the hospital.

Another strategy concerns the 200 milligram form. We believe that both strategies will help. It is by far not the only strategy we apply. We have put a number of programs in place to keep our customers in economic terms. For Eloxatin it is the same strategy as for all our other products. We will not let the volume of this product go to generic competition. We fight for it, in order to keep the patient on the same product, and also to keep our relations with our prescribing doctors.

So on the page 20 then, the situation of the vaccines. You see once again this sequence of 7%, which I have outlined before, it's an [artifact]. And if you look to the green segment of influenza, you see that there is a very sharp decrease. And if you switch then on the next page, you see that this is the delay which you may have heard in similar conferences from our competitors. There have been issues with two new strains in this season's vaccines. Also low yielding introduction, and so we are all delayed. But it is clear that we will fully recover those under delivery during October and November.

So far on the product and I hand now over to Jean-Claude concerning the financial.

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Thank you, Hanspeter and good morning, everybody. Hanspeter already addressed most of the main factors which impacted our P&L during this quarter, so I propose that we go directly through the figures. And we will follow from page 24 to 30 while keeping an [eye] on page 22, 23, which are the details of the P&L.

If we begin by the first line, the top line, we have to mention what happened on the parity of the US dollar versus euro during that quarter. And as you can see, there has been a decrease in the value of the dollar during this quarter of about 4.4%, which explains most of the impact of exchange rate during that quarter, -2.4%. So when we are looking at the sales from a P&L perspective we are starting with a -4.2%, which in turn translates into a +3.5% on cumulative nine month basis.

Now I propose that we move to the gross margin ratio and I will give a word first to begin on the other revenues. Simply because this is there that we book the royalties coming from the sales of Plavix in the US and you see the downturn by 24%, which is totally explained by the low level sales we saw during this quarter. I remind you the figures, we sold EUR377m of Plavix in the US during this quarter and that's the reason for which the level of this other revenue line item has been decreasing.

[Despite] cost of sales is constant, you see a decrease by 1% or an increase I should say of the cost of sales by 1% when you compare to this quarter 2005. Now this is also to be compared to what happened during the second quarter, or the first quarter of 2006. And I remind you that we have a quite comparable level to these two first quarters of 2006. In other words, the impact of the [four] generic products had a [inaudible] during the -- mainly during the fourth quarter of 2005, of course impacting our cost of sales by about 1%.

I have to comment, the next line items, which are R&D and selling and general expenses. When it comes to R&D, as you can see, we are still continuing making efforts in this area. We are showing an increase by a little bit over 8% during this quarter. It is 11% on a cumulative basis, so as we said earlier in the year, R&D is one of our focus this year. We have a lot of programs to finance this year and this is reflected directly in the P&L.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Going down to the selling and general expenses, yes, there is a special word to address this quarter, because as you can see, there is a decrease by 10.5% of this line item as compared to last year.

Now it is fair to say that during the quarter we didn't have any promotional effort on the genericised products, but that is nothing new as compared to previous quarters. But, in addition to that, as Hanspeter was addressing the measures which were taken by the various governments in France and Germany, the cost containment measures, he said that the press echoed the kind of adaptation measures we took in the group as a reaction to this situation, as well as the issue we have been encountering in the US with Plavix, and it's also fair to say that this is a period where we took some internal measures which had a rather quick effect on the level of expenses just because we felt it was appropriate to react to the change in the environment. And this is the main reason for which you see that downturn in selling and general expenses. I have to confirm that as far as the G&A part of it, G&A are continuing to decrease as they did since the beginning of the year.

If we move now to the next line item, the other current operating income and expenses, just a word to tell you that this quarter we have recognized gains in foreign exchange. It is to be compared to a loss encountered in the third quarter of 2005. And this is quite normal when we remember the variation of the parity between dollar -- US dollar and euro during this quarter, and also because of the policy, the hedging policy we've been doing during this '06 year, we are now realizing some gains just because the dollar is weakening.

So that shows that also on a cumulative basis, and I remind you that in these line item that's also where we group the contribution from Prasco, this US company, which we were to sell the authorized generic of Allegra in the US.

So, all in all we come to an operating income current of EUR2.5b in the third quarter, which is a down I should say of only 6.5% or limited to 6.5%, and which is still showing an increase by 4% on a cumulative basis despite all the kind of impact of generics we had during -- and measures, cost containment measures we had during this period.

If we go down a little bit, page 28 now, from operating current to operating income, I have no comment -- no further comment to make for the Q3. And you would remember that on a cumulative basis we have a very huge positive amount, which is mainly reflecting the kind of capital gain we made on Exubera, the remaining stake of Animal Nutrition and so on, nothing new in this quarter. I will be back on the specific items in a little while.

Net financial expense. Now you see an expense which is of EUR50m in the Q3, which is to be compared to EUR19m in Q3 of '05, so that deserves a little explanation because this is not the usual sense of this line item. It is fair to say that first there has been a reduction in the net debt during the third quarter. We'll see that we improved the cash -- net cash position of the Group by around EUR1.4b during the third quarter so interest charges were lower than in Q3 '05, EUR92m as compared to EUR104m.

Now, in addition to that you may remember that last year we had capital gains which were generated on some biotech companies and that's most of the difference. If we also add up the last line item, which is shown on your slide, which is the foreign exchange gains, which are rather important this quarter as compared to last quarter simply because we are hedging also hedging the US debt instrument, the [inaudible] [USCP] we are drawing on during this period. On a cumulative basis so, again, an improvement, EUR146m to be compared to the EUR224m, and that despite of the fact that in '05 there was this capital gain as I just mentioned.

I have no special comment to make on the tax rates for Q3, so I move to page 30 to give a word on the share profit and loss from associates. Once again, as I mentioned, on the royalty line a little earlier, there is the impact on the Plavix in the US situation and you can see that directly in the contribution, which comes from the BMS alliance Territory B, what BMS is managing, where you show a sharp decrease of this contribution, EUR56m after tax income, to be compared to EUR112m last year. This is the main component of this decrease. That also shows that obviously in the cumulative but not at the same pace since we were [doing it] in advance as of -- at the end of the first half of the year.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Minority interests, nothing to mention. You remember that the main component of it is the share of profit we rendered to BMS on the Plavix and approval mainly in Europe, and this is going well as Hanspeter described earlier. So we are giving back more money to BMS than we did last year, EUR100m to be compared to EUR91m.

So as we do usually now, let's have a look at the impact of these famous selected items on the adjusted net income. And as you can see directly from slide page 31, there has been none of them during the third quarter, and this is to be compared to a positive impact of more than EUR100m of after tax income last year, which in turn drive us to the bottom line. You can see that from two angles. The first is bottom. Not only you see a decrease by 12.5% at the level of the EPS, EUR1.25 [sic - see documentation], but you can also mention and keep in mind that this third quarter was only a decrease by 7.4% at the same level EUR1.26 per share.

On the cumulative nine months now we are showing an adjusted EPS of EUR4.21 a share, which is up 15% on the nine months end of September '05. Again, fair to say that excluding these selected items, it was EUR3.87 up 7.5% as compared to the same period of last year.

I already mentioned that we made a positive cash flow of EUR1.4b during this third quarter, so adding that to the EUR1.1b, which we realized at the end of the first half. We are now up to +EUR2.5b as compared to the situation of the first of January, so our net debt is down to EUR7.4b and it's an improvement of the gearing, as well.

As a conclusion I must say a word about the guidance for the 2006 results. What happens since we moved, you remember, from [+12%] to around +2%, and this was at the very beginning of September. On Plavix in the US we've made some sales since August 8. We've made [\$85m off sales]. One of the assumptions you have to remember was [0] sales. So as well we will have probably certainly some sales of Plavix in the US during the fourth quarter, but that doesn't mean that we are able to predict the figures since [stocks] may not be distributed equally among channel participants. And as Hanspeter mentioned, because of the confidentiality clauses, we are not yet able to get very good information about what is in the channel.

Another issue, we started to work on adaptation plans and associated costs will arise by the end of the year. While cost containment measures, we mentioned that in France and Germany, the [growth] that they are expected negative effect during this quarter. And again, Hanspeter mentioned that we are seeing additional measures, which are taken in other European countries, just to mention, Italy and Portugal.

So all in all, taking all of that into account, we decided that we could change a little bit, if I may, the guidance for 2006. And we can now say that we expect an increase of at least 2% as compared to the 2005 figures. And again, this is bearing any unforeseen events. And again I won't go through the details but it is the same expression as we already mentioned in September. I mean by that with the priority of \$1.25 to the euro with EUR300m of selected item and so on. Nothing change in this definition. So, small improvement in the expression of our guidance we can say today with what we've seen on the Q3 results I just give comment on.

Sanjay Gupta - Sanofi Aventis - VP, IR

Thank you, Jean-Claude. We can move to the question and answer session now. Operator?

QUESTIONS AND ANSWERS

Operator

Thank you. Ladies and gentlemen, today's question and answer session will be conducted electronically. [OPERATOR INSTRUCTIONS] Our first question comes from Matthew Weston of Lehman Brothers. Please go ahead.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Sanjay Gupta - *Sanofi Aventis - VP, IR*

Matthew?

Matthew Weston - *Lehman Brothers - Analyst*

Can you hear me, gentlemen?

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Yes.

Jean-Claude Leroy - *Sanofi Aventis - EVP & CFO*

Yes.

Matthew Weston - *Lehman Brothers - Analyst*

Okay. If I could ask a couple of questions please. Firstly, on your statement around the US Acompli, could you just confirm that your confident that you'll get a class one status for your review from the FDA, so we should therefore assume an action date at the very end of the year?

And then just quickly coming to your oncology portfolio where I have to say sales look a little bit disappointing, could you touch on why US Taxotere has underperformed so much given the pictures on slide 18, which highlight how much market potential there remains? Is it competition from Abraxane and with Astra's involvement there should we be increasingly concerned about growth rates?

And similarly with the Eloxatin, I sense a real change in your tone about the generic competition in Europe. Previously you stated a great deal of confidence that your life cycle management would retain the vast majority of market share there, but I now seem to sense that you're actually maybe stepping back from that commitment and whether we should expect considerable generic erosion.

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Yes, Matthew, thank you. Let me say an answer first on that one and before summarizing once again what I said before. First I said that we have an extremely positive reaction to the product from physicians and consequently from patients in Europe wherever we have launched the product so far, and I have mentioned that the product in Germany and in UK does better in the first week of launch than the most successful benchmarks we have in [inaudible] and out [inaudible].

Second, I have said that we have advanced well in terms of reimbursement with the exception of Germany where we have continued to fight. I may add that the decision in France is imminent.

Third, I have said that our lifecycle management is on track and that we are looking forward to the publication of the Serenade study in diabetes patients before the end of the year.

And last but not least, I have said that our people in Research and Regulatory have made their homework. Since we have had received the approvable letter on February 14, they have worked and they have submitted October 26 a complete response to

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

this approvable letter. I really kindly ask you to understand that beyond this we will not speculate at all what the FDA now has to do or will do and within which timeline.

Matthew Weston - *Lehman Brothers - Analyst*

Can I just ask one quick follow up on that? Because as I understand it, within 14 days of your complete response the FDA is required by law to inform you whether it's a class one or a class two review of your data, which either gives us a two or a six month timeline. So will you make a public statement when that 14 day timeline is up, to the market, which will inform us whether it is a two or a six month review?

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

From what I see today we will not make a public statement until we have a reaction from the FDA.

Matthew Weston - *Lehman Brothers - Analyst*

Okay. If we can move on to oncology then?

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Yes. Now on oncology, on Eloxatin perhaps, I'm a little bit surprised that you quote me that I would have said that through various measures we would succeed to [offset] generic inroad in Europe. I would not know any example where this would have been the case in the past. I think it is fair to say that overall generics in oncology have a slower penetration than in any other indication. But of course you have to make concessions in terms of price, in terms of rebate, and this in spite of lifecycle management measures. If I look to very competitive fields in which we had to compete with generics in Europe recently, looking for example to Stilnox, we succeed to maintain volume [wide] shares between 50% and 70%, to give a reference. And what I tried to say earlier is that we will try to do the same in a field which usually is not so open to generic penetration [inaudible], as for example Stilnox had been

Now to give a precise estimate how this will develop over time, frankly I feel not able. It also has to do with open questions if the generics will come immediately or only later with an [aqueous] solution, what the sustainability of stock is concerned and [inaudible]. So we are confident to sum it up that even over time we will keep the majority of volume sales, volume sales of course, not value sales, of Eloxatin in Germany and in Europe, but this is a process over the next years as the patent and the data protection goes off over a spread period of approximately 24 to 36 months all over Europe.

Now back on Taxotere in the United States, well, unfortunately I can say nothing really new. The product has had I would say an unfortunate history in the United States. First of all it was launched in the United States against [Taxotere, Taxotere] was really considered as an American development of American oncologists while [inaudible], excuse me, while Taxotere was a product coming from outside, coming from Europe. I have indicated in earlier calls that we believe that the management of the drug has not always been optimum during recent years. And yes today the product is in a competitive field, and an [important] one, which is more intense than in recent years. We tried to work on all those fields so far not with the success we success we wished to have, but we feel encouraged by the recent approval of the fifth indication, which should give a backwind to Taxotere also in the United States, and could even more as we see that outside the United States the product does reasonably well, so in any case, significantly better than [there].

Matthew Weston - *Lehman Brothers - Analyst*

Okay. Thank you.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

Thank you.

Sanjay Gupta - Sanofi Aventis - VP, IR

Could we have the next question, please?

Operator

Thank you. Our next question comes from Graham Parry of Merrill Lynch. Please go ahead.

Graham Parry - Merrill Lynch - Analyst

Good morning. Thanks for taking my questions. A few on the Serenade study, please. I just wanted to confirm whether the Serenade data has formed any of your new filing package or complete response submission, and was any more safety data from this study needed for the complete response? If that hasn't been filed, could you give us an update when you do expect to file that? And perhaps your thoughts on whether a 280 patient study would be sufficient for a full indication for diabetes or if you'd just expect this to be a data label enhancement?

And then just on the SG&A line in the quarter, I was wondering, was there any pre-launch activity for Acomplia in the US? We're seeing SG&A has not increased for several quarters and you had indicated you'd expect to see some pre-launch activity second half. Given the seemingly slightly delayed timelines on Acomplia, have you actually been engaging in any pre-launch activity in the US? Thanks.

Sanjay Gupta - Sanofi Aventis - VP, IR

Graham, [inaudible] the answer to your question, but first we would like to see the results, and then we would need to discuss with the regulatory authority so it's too early to answer any of those questions.

And on Acomplia in the US, perhaps Hanspeter, would like answer?

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

We maintain our pre-launch activities in the US, of course. I dare to say perhaps we may have even a certain gain from the delays launching to the US simply because we have more time to prepare the [inaudible] of the launch. But all the reductions we have made in the United States have been reductions totally outside the pre-launch program for Acomplia.

Graham Parry - Merrill Lynch - Analyst

Okay. Thanks. And if I could just have a follow up as well. You're talking about the -- proposing limiting the patient population for Acomplia in Germany. I was just wondering have you made any similar proposals to the FDA, and have you discussed a patient registry with them in your discussion?

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

That's really within the statement I made before on what we want to say on the answer to the approvable letter. But, nevertheless, I dare to say once again that the reimbursement situation in the US is quite different from the situation let's say in Germany. The decision making in Germany is much more related to the exact phrasing of the indication you have, while in the US, as you know, you have to talk of [payers in direct] in order to obtain the [inaudible].

Graham Parry - Merrill Lynch - Analyst

Thank you.

Operator

Thank you. Andrew Baum of Morgan Stanley has our next question. Please go ahead.

Andrew Baum - Morgan Stanley - Analyst

Morning. A couple of questions. First, on the performance of Eloxatin in the US, is this simply a slack growth because you had a tough comparison in Q3 last year? Or is there any sense that oncologists are restricting Eloxatin use because of the burden of the monoclonal costs?

And then second, could you discuss or give us some indication to the extent that Sanofi participated in forward contracts on Plavix in order to try and stem the impact of the Apotex product, just thinking about how the long term dynamic may play out here?

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

On Eloxatin, Andrew, good morning first. Eloxatin, I think we have quoted both effects. Yes, it is true that we have a little bit of an unfavorable comparison with the previous quarter and that TMs why I expect the fourth quarter will show a stronger growth than the third one.

The second is what I said for Taxotere is even more true for Eloxatin. We cannot overlook that in the adjuvant treatment of colon cancer we have to take a penetration of about 60%. So in this [inaudible] indication for Eloxatin in the United States we have to admit that we get to a level which is probably the optimum and it will be difficult to grow further. In first line metastatic we have 55%, which of course is a fraction also of the 60% we have on the other side in adjuvant. So there may be some room there but overall it is a mix that is [set] previous quarter and the high penetration of the product. I see no direct relationship in conflict with the monoclonal.

Sanjay Gupta - Sanofi Aventis - VP, IR

We can only add that we are working to get stage 2 adjuvant cancer patients, and that's something we'll decide in next year whether we have favorable data. Because right now we have the stage 3 adjuvant indication and we are looking at stage 2 which might be an additional reservoir for the future.

Andrew Baum - Morgan Stanley - Analyst

Thanks a lot.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Now as far as your question on ongoing negotiations with the healthcare providers in the United States are concerned. Yes, in the period when the generic entered the market and when the generic had to go off of the market, of course we have been active with healthcare providers and have made proposals. It is sad to say that because the period was relatively short and also the other circumstances of the [inaudible] launch, the success of those offers has been limited.

Nevertheless, we are today, of course in the reverse position. We are now renegotiating our conditions with the providers for the time when the stock has been exhausted. And we have to see that in a number of accounts not a dramatically large number but nevertheless, a number of accounts, we have seen this regarding in terms of tier position and we have [inaudible] next week, for which expenses oblige us to make concessions, but as indicated earlier, it's a little bit too early to come to a conclusion.

Andrew Baum - *Morgan Stanley - Analyst*

Thank you.

Operator

Thank you. We will now move to Phillipe Lanone of IXIS. Please go ahead.

Phillipe Lanone - *CDC IXIS Capital Markets - Analyst*

Good morning, gentlemen. Just a quick question. On your guidance you still include EUR300m of exceptional [inaudible] items and that means that you will have a strong negative in Q4. What do you expect here, or do we have to up a bit the guidance to be realistic on this ground?

That TMs okay. My other question has been answered.

Jean-Claude Leroy - *Sanofi Aventis - EVP & CFO*

Okay. Again, on these specific items, selected items, remember that when we expressed to you the guidance we said taking an assumption of EUR300m. Now it's for the sake of being able to make a comparison with the year earlier. Obviously this is not saying at all that the actual level of these specific selected items will be EUR300m. So you cannot draw the conclusion that we are going to end up in the fourth quarter with a negative by more than 200.

I have already mentioned the fact that this line item is made mainly out of unpredictable items. So it's fair to say that we are both -- or close to EUR500m cumulative on a nine month's basis but this has nothing to do with it, again, with the expression of the guidance. It's just for you to be able to make a quick and accurate calculation. Because you remember that last year we had EUR165m net of tax of selected items, so you make your calculation taking 300 into account. Now we may end up differently. We will certainly end up differently. I am not saying it's going to be 500 or something different, but I am not sure. That's because of the specificity of this item. Making capital gain on disposal of a set, or booking the difference between results which were made on [things] of the past and what is going to be the reality. Whether we're talking of tax or legal matters, I don't think it's proper to include that as a judgment on how the Group is going on a day-to-day basis. Reason for which again, we are talking of figuring [itself] for the assumption, so please, if you can just stick to that and make no interference, what's going to be the actual result in this line item.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Phillipe Lanone - CDC IXIS Capital Markets - Analyst

That does not mean, so, that there will be a further restructuring plan booked here on this line in the Q4?

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Oh, as already mentioned, you've seen the [inaudible] some adaptation measures, which have begun to be taken in France, in Germany, and so on. So yes, there will be some restructuring costs, probably at the end of the year. Now I'm not saying that these items are selected items, and so don't make any confusion. Keep in mind the 300 without mixing, it's something which is different, and don't worry about that.

Remember, when we delivered the change in guidance at the beginning of September, we explained why there was such a decrease between +2 -- +12 and +2. There were two components. The first one was Plavix in the US because of the launch of the generic by Apotex. And we said at the time that we took an assumption, once again, that there would be no sale up until the end of the year. And in addition to that, we would be behind the product, so spending the necessary monies to make sure that the stock of generic would go as quickly as possible out of the market, so a negative contribution. This was the first line item, and the second line item, less important obviously, was these measures of adaptation. So yes, we will see that but this was already included in the change of guidance. Today we are saying instead of around 2% -- +2%, we are saying at least 2%, but that doesn't change nothing. These items, I mean the restructuring, will also be included in this -- are included in this new guidance.

Phillipe Lanone - CDC IXIS Capital Markets - Analyst

Okay, understood. And if I may follow up with another one, a quick one on inventories, because the Q3 figures were on the consensus on several of the big products, is there any significant inventory variation somewhere on these drugs?

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

No, not at all.

Phillipe Lanone - CDC IXIS Capital Markets - Analyst

Okay.

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Not at all.

Phillipe Lanone - CDC IXIS Capital Markets - Analyst

Thank you.

Operator

Thank you. Our next question comes from Sebastien Berthon of Exane. Please go ahead.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Sebastien Berthon - Exane BNP Paribas - Analyst

Yes, good morning, gentlemen. Sebastien Berthon from Exane. A question on Europe decline. The major reasons for the declines we would have expected to be on the [base] products, which gets quite a lot of control, while some of your major products have been suffering quite a bit. Lovenox, up 4% versus 9% in Q2. The Plavix 4%, 8% in Q2. Taxotere 7%, up 23% in Q2. What are the main reasons behind the declining growth for these products? Could you give any [inaudible] for these products, if any? That would be useful, thanks.

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Yes, in very general terms, if you could look to the respective sales in France and in Germany you would see that at least in the events which we suffered in the third quarter it was, in fact, a major product, which was [flat]. We had, as I said before, a price reduction of let's say Plavix in France, which led to the effect that in the third quarter the stock of Plavix in France has been significantly reduced because for evident reasons wholesalers destocked. If you look to Lovenox we had the same situation in Germany all during the third quarter, with the consequence that the wholesalers and the hospitals destocked.

So our major product in Europe has been [struck] by the interventions, by tax, by price decrease, by increased measures around reference prices in Germany. And yes, as I also said before, the impact on the so-called base business has been a little bit less pronounced. So, as you see there's even a little bit of [inaudible] in terms of 2 to 3% negative growth on the base business.

This is really the issue in Europe now. Today in Germany and France, it is very difficult to know what to do because it's not about the fact that only the base business is hit by the measures, no, also [those] products. I could give you another example, which is Aprovel in Europe, and in most markets we see price reductions consequently to the reference prices which are in place.

Sebastien Berthon - Exane BNP Paribas - Analyst

Okay. Thank you.

Operator

Thank you. Our next question comes from John Murphy of Goldman Sachs. Please go ahead.

John Murphy - Goldman Sachs - Analyst

Yes. Good morning, gentlemen. First, could you give us a little bit more information maybe around France and Germany in as much as you did mention there was rapid savings there? Can you tell us a bit about that, was that sales force? And do you think that had any at least short term adverse top line impact?

Equally, how should we think about the selling component going forward in terms of one time benefit versus ongoing savings?

Second, on inventory, you mentioned reduction in inventory in France and Germany. Are we now at very much a low here in terms of inventory? Could we maybe hope for a bit of an opposite move in the next quarter?

And then finally, on Ambien, just wondered if you could give us an update in the US on the percentage of tier 2 status for Ambien IR and CR. Thanks a lot.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

So on this situation in France and in Germany, the immediate effect which we had in France and in Germany are external sales force. Usually those sales forces can be terminated with four to 12 weeks [inaudible] and this is what we did. We did this in Germany and in France. On the other measures it is too early really to quantify, but yes, overall we say if we are losing 10% of sales as an indicator, we aim to reduce our sales forces proportionately. But we do the same in the management and there has been publication of the French figures by the French subsidiary where you see that we don't stop with the sales force. No, we say if we have a reduction in sales force, we have to make adequate reductions also in the local headquarters, I believe for obvious reasons.

Those measures take more time. We, of course, have to dialogue with the partners. To put them into place will take more time but the overall direction is this. Where we have issues we address them in cost reductions. We have done so in the United States already since the beginning of the year, even since the end of last year. Consequently, [you see a lot of] [inaudible] the same as for product including Allegra.

We have to do this with prudence, and we try to do so, and [this for] the US even more because we are preparing for the launch of Acomplia, but I can't exclude that we undergo real risks on the remaining business. But yes, we have to address this. If we lose our products in the United States, necessarily we have less means for sales force capacity, and yes, if products lose 10% to 15% of their price we have to address this to some extent in the investment policy.

Now on inventory, very difficult. I also don't want to give a guidance on the fourth quarter. If you look to the French market, according to [IMS] you may see a certain recovery in the value in recent weeks and months. This is also true for the US where you see, and as I said in my presentation, that the market is coming back to some extent. [Medicaid] will play a role in this as well. And yes, in perspective of the US market I am relatively confident that we will [terminate] the market close by the end of 2006 superior to what we had seen in the first quarter. As I said before, our stock worldwide is low so consequently if you put the two factors together, yes, I am carefully optimistic for the fourth quarter.

Sanjay Gupta - Sanofi Aventis - VP, IR

And John, on your question about inventory, about Ambien and Ambien CR?

John Murphy - Goldman Sachs - Analyst

No, it was about the tier 2 status on Ambien and Ambien CR.

Sanjay Gupta - Sanofi Aventis - VP, IR

Okay. So Ambien CR is gaining tier two status. The last time we shared with you it was about 15% in tier two life. And it is to be measured in terms of life, because I think [inaudible] from some other companies which measures it in terms of account, and that can give you a misleading picture. But in terms of life we're up 15%, and it's very, very [complicated] [versus Lunesta]. I think maybe we have about [50% to 75%] additional life compared to Lunesta.

John Murphy - Goldman Sachs - Analyst

Thanks very much.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Operator

Thank you. Tim Anderson of Prudential has the next question. Please go ahead.

Tim Anderson - Prudential Equity Group - Analyst

Thank you very much. Just a couple on the Acomplia if I can. I understand that you don't have an answer from FDA, but I'm hoping you can say whether new clinical data was resubmitted as part of your resubmission, or whether it was just a reanalysis of existing data.

And then on Serenade, your comments as part of the prepared remarks, makes me think that you've seen the full results and now it's just a matter of releasing them publicly. I'm wondering if that's a safe assumption.

And then a third question on Eloxatin in the US, and when we might expect to see generic competition with that product?

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

So on FDA and Serenade, look, to a certain extent both questions are related. What to say? I think it is for good reason good practice not to talk about the results of a study because -- before it has been exposed to the academic and scientific public. This is the case with Serenade. This is imminent because it will take place in approximately four weeks from today, so I kindly ask you to accept this as a statement. I can really not go further. Of course we are looking forward to the study with a lot of confidence because it's important, it's a landmark study for the further development.

Sanjay Gupta - Sanofi Aventis - VP, IR

And on Eloxatin, Tim, basically we have three types of protection. The first one is data protection, which expires in August of 2007, and this has been further extended by a period of six months due to the pediatric extension, which we have received from the FDA. Furthermore we have two patents. The patent on the [like for like] version expires 2013. It's a slow process the product patent, the security patent, and we also have a patent on the solution formulation, which expires in 2015.

Tim Anderson - Prudential Equity Group - Analyst

Okay. So on Eloxatin, you're basically saying no generics from the U.S. within the end of the decade?

Sanjay Gupta - Sanofi Aventis - VP, IR

Yes. That is the worst case scenario you can imagine in our view.

Tim Anderson - Prudential Equity Group - Analyst

Thank you.

Operator

Thank you. [Jo Remyer] from Dresdner Kleinwort has our next question. Please go ahead.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Ben Yo - *Dresdner Kleinwort - Analyst*

Hello. Can you hear me?

Unidentified Company Representative

Yes.

Ben Yo - *Dresdner Kleinwort - Analyst*

It's [Ben Yo] at Dresdner actually. It's just two or three quick questions. One was in terms of SG&A. You spoke of the less expenses in France and Germany and the less G&A expense. I just wondered how sustainable this is. Is this the absolute level we're going to expect now?

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Excuse me? Could you repeat your question? It was phonetically not understandable for us.

Ben Yo - *Dresdner Kleinwort - Analyst*

Okay, can you hear me better now?

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Better now, much better. Yes. Thank you.

Ben Yo - *Dresdner Kleinwort - Analyst*

In terms of the expenses in France and Germany, you talk about less general expense and also savings in your SG&A line. I just wondered how sustainable this is. Is this the absolute level we're going to expect now?

Also on restructuring, I was just wondering what the financial impact on your plans for restructuring are likely to be, either in Q4 or into 2007?

And then, lastly, just on Ambien. I was just wondering, can you confirm your expectations on Ambien generics and how your strategy for the switch to Ambien CR is progressing?

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Perhaps I will start with Ambien. I said before that we have, as of mid of October, about 32% switch rate. We gain between one and two points per month. We have about six months or seven months more to go so, from a purely mathematical point of view, yes, we confirm our original ambition to get close to 50%. Even more, as we see today, that the switch rate is absolutely on the level of the most successful switches so far [for drugs] the United States.

Now on the situation of cost and cost saving in France.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Well, cost-saving in France and maybe Germany and a bit also in the United States just that these countries, which has been impacted by the various situations we mentioned earlier. Hanspeter said, as already mentioned, we need to finish the negotiation with the partner. Therefore we today we feel that we will know more about the cost by the end of the year so you will know more about these costs by the end of the year, probably in the closing of the 2006 books. And as far as the synergies, which maybe drive from these measures are constant, they obviously will be included in the '07 guidance and therefore you will have a [inaudible] of that included when we deliver the '07 guidance next year.

Ben Yo - Dresdner Kleinwort - Analyst

Thank you.

Operator

Thank you. [Stuart Close] of HSBC has the next question. Please go ahead.

Stuart Close - HSBC - Analyst

Yes. Thank you gentlemen. Two quick questions. First of all Monsieur Leroy, just so I understand exactly what you were saying in terms of the full year 2006 guidance. Are you maintaining the view that EUR300m will be the other operating income figure and is that the sort of assumption we should plug into our spreadsheets to get to the 2% guidance? Because, as it stands at the moment we've got adjusted EPS of 421 for the first nine months. The implication being that you're on minus 41% Q4 EPS figure for 2006. Now if that's because we can have a big restructuring charge, that's fine, but just trying to understand if that indeed is the correct assumption.

Secondly, can I ask the Acompli question again? I think the market is just trying to understand -- everybody appreciates these negotiations are very difficult but obviously the market's just trying to understand, are we on a clock? Was additional data submitted? Was additional data not submitted? And how have we gone from your earlier comments in the year, which said this is an Ambien type review process to less certainty? Thank you very much.

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Okay. On the guidance and the selected items. Remember that in last year, in 2005 and I'm talking of the full year now, the bottom line was EUR6,335m of net profit. In that were included EUR165m, all round, net of tax on selected items. And when we expressed the guidance for the year 2006, we had to choose a way to convey this guidance. We said, let's take the last one, when we are saying 2% with EUR300m of selected items in 2006, that means that you take up a nominal EUR300m, whatever the actual figures are or will be on the selected line items. Now, that being said, again that wasn't said that we were going to end up with EUR300m -- I'll give you an example.

We were at close to EUR500m as I mentioned earlier at the end of September. You very well know that during the fourth quarter we sold our [inaudible stake to] the market and therefore, we're going to encounter a capital gain on this one, which is going to be a little bit under EUR100m net. So, once again, the EUR500m may become close to EUR600m before anything else happens. So, I am not taking that into account when we give figures for the guidance. It's just -- the 300 it's just to help you to make the calculation of what is going to be the bottom line, excluding these selected items.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Stuart Close - HSBC - Analyst

Okay. So, EUR300m is 2%? That's how we think of it?

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Yes. And now, in addition to that, we never included -- I mean never since the summer, we did not include any restructuring charge to come because of the cost containment measures, which [inaudible] had to [inaudible] and that [special] measure, we never included that in selected items. This is directly included in -- if I may, in the ordinary bottom line and this is included in the former plus -- around -- plus of 2%, which became today at least 2%. So this is -- the burden is taken into account in this situation. And I mentioned obviously that the main component was the Plavix one.

So, I hope that it becomes a bit clearer for you. Don't measure the selected items as a driver for the bottom line of the company because, once again, there are [inaudible] positive, maybe negative, reasons for which we're giving you as some time as a driver is that level of [inaudible], but that doesn't mean at all that we're going to finish up with a figure with this level of EUR300m.

Stuart Close - HSBC - Analyst

Okay. Thank you.

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

Now on our country at large, I think you have used the word negotiation and I have to be clear that we are not in the process of negotiating this American authorities, the approval of the product.

Stuart Close - HSBC - Analyst

Yes.

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

That TMs not the way it work. We have received an approvable letter and usually, and also in this case, an approvable letter contains questions. We have answered to those questions and as the approvable letter did not ask for new additional clinical trials, consequently it is easier for me to say that we have not submitted new data in this respect.

I may refer perhaps to, an erroneous report on the potential usage of European safety data, which has been issued a couple of weeks ago by Bloomberg. You may have seen that we have made a [inaudible] to this because if this was evidence, it was flawed.

So, to sum it up. We have made our homework. We have answered the questions. We have submitted this and all speculations from there on is useless and we will not do so.

Stuart Close - HSBC - Analyst

So when we're talking -- when people are talking about a three-month or a six-month additional data review period; that might just be, a complete fallacy as well? It's just the FDA now has to sit and decide what they do with the response letter. Yes?

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

Yes. The FDA is totally free in its decision-makings. This is good. This is in the best interest of the patients and, at the very end, also of the industry.

Stuart Close - HSBC - Analyst

So we're not on a clock?

Sanjay Gupta - Sanofi Aventis - VP, IR

We have just submitted. We have not received anything. There are more [inaudible] to be made and as Hanspeter said earlier if there is any major clear information, we will issue a press release.

Stuart Close - HSBC - Analyst

Okay. Thank you very much indeed.

Operator

Thank you. We will now move to Amit Roy of Citigroup. Please go ahead.

Amit Roy - Citigroup - Analyst

Hello. Thank you. I just have got two questions. So, firstly a question on the Ambien switch. Looking at the IMS data that we have, it's true that Ambien was switching at about 5% per month, over 1% per week as you say. But more recently that seems to have dropped to 1% per month, so it's about five times less. And that seems to me, it's on track to get to the mid-30s for the switch. And I also noticed that your pricing scheme, you now priced -- you had Ambien CR priced cheaper than Ambien to encourage the switch but that's now -- but they're now both part of the same. With those factors in account, how do you see yourself getting to the 50% switch rate? And that's the first question.

And the second question, regarding Acomplia, I understand that you are unable to talk about the negotiations -- discussions with the FDA, but your February press release stated the approvable letter for Acomplia in weight management. Is it a normal process when you have a resubmission that the broad indications, i.e. weight management stays the same or are you free to change that to something else; i.e. say diabetes or [inaudible] for example? Thank you.

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

Look, I really don't want to be rude but I have nothing to add to what I have said so far on Acomplia. I kindly ask you to accept that, for the reasons given, the -- our relations with the FDA are driven by this fact and in this sense we don't want to continue to add piece of piece of information, which necessarily becomes speculation.

Now, as far as the switches in Ambien are concerned. First of all what we are looking to is repeat prescription data, which has to be looked to with care. The data is not the most reliable data, which is available. If you look over time, we remain confident that we will have a switch as the major product, which has been switched in recent years and this is inside my presentation, which shows product R. We believe that the switch will develop about 40% and we have given as a medial or as a maximum objective a switch rate of 50, so I remain absolutely confident that the switch will be well above 40, close to 50.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Amit Roy - Citigroup - Analyst

Thank you.

Operator

Thank you. Michael Leacock of ABN AMRO has the next question. Please go ahead.

Michael Leacock - ABN AMRO - Analyst

Hi. I just have a question really on Acomplia in France, if I may? I know you said the decision is imminent and I know you wouldn't want to jeopardize any discussions or negotiations with the French. Could you just highlight what is different between the view of the French reimbursement system compared to Germany? What gives you, perhaps some confidence that the French will be rather more open-minded to Acomplia than the Germans seem to have been?

[Technical difficulty].

Operator

Ladies and gentlemen. We are currently experiencing an interruption to today's conference. We will be continuing shortly.

Unidentified Company Representative

Hello?

Operator

Mr. Leacock, please go ahead with your question.

Michael Leacock - ABN AMRO - Analyst

Hello, Michael Leacock again. In France you mentioned that there's [inaudible] for Acomplia and you wouldn't want to prejudice that discussion in any way, or outcome. So, I just wondered what the different process is in France in terms of what factors it will consider for company reimbursement, compared to say Germany where we've had a rather more tough time?

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

The difference in fact are really very different. I would say the major difference is that inside the existing system in France you can make agreements on sub-populations of patients. So you can say, okay we have a relatively vast indication from the A and the R but the product will be limited in its reimbursement on the sub-population.

In Germany this so far is not foreseen. There is to my knowledge only one exception to it, which is oral contraceptives in Germany, where oral contraceptives are being reimbursed to young females, I think until the age of 20 or 21, but the approach in Germany is rather different. I feel it's also a little bit unfortunate because the medical indication is not necessarily the, let's call it, reimbursement indication, while in France and also in Italy and also in Spain, it's a well-established practice to reimburse for [inaudible] of the overall population. Is this answering your question, Sir?

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Michael Leacock - *ABN AMRO - Analyst*

Thank you very much.

Operator

Thank you. Our next question comes from Ben Yo of Dresdner Kleinwort. Please go ahead.

Ben Yo - *Dresdner Kleinwort - Analyst*

Thank you. I just have one very quick follow up question as to whether [Itaparanox] was still on track for an update in December or where we were with that?

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

The answer is yes.

Ben Yo - *Dresdner Kleinwort - Analyst*

Thank you.

Sanjay Gupta - *Sanofi Aventis - VP, IR*

That will be presented at the American Society of Hematology in December.

Ben Yo - *Dresdner Kleinwort - Analyst*

Great. Thanks.

Operator

Thank you. Alexandra Hauber of Bear Stearns has our next question. Please go ahead.

Alexandra Hauber - *Bear, Stearns - Analyst*

Good morning. Thank you for taking my questions. Just a couple of follow up questions on the impact on healthcare reform. First of all, in the press release you mentioned parallel imports. Could you tell us which products in which country are affected?

And to just come back to Germany again, you mentioned the Plavix intervention and price cut. If I did understand that correctly, could you just mention exactly what happened in Germany to Plavix?

Then on France, the general question is, I don't understand how you can explain that you have been affected worse than the market by having a big market share because why wouldn't you be benefited in line with the market?

And could you just quantify the price cuts you have added for Plavix in France?

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

And then just a follow up question on the adaptation measures you have already had, which were restructuring costs, where -- which you said, these are the temporary sales forces. When exactly did you drop them? Did you drop them straight at the beginning of the quarter or somewhere halfway through the quarter?

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

First of all, on importation. So, first of all it's the market which is most concerned is the UK and Germany. In the UK it's more or less nearly every product. In Germany the products mostly concerned are Plavix, simply because the German price is amongst the highest prices in Europe and to a lesser extent, Lovenox. So, having said so, where does the product come from? They come mainly from the low-price countries for both products, which are for example, Greece, France, Spain and in the case of Lovenox we see also importation meanwhile from Poland, which is raising new issues for evident reasons. Now --

Alexandra Hauber - Bear, Stearns - Analyst

So, Poland -- can I just -- you said that Poland is the new element in the parallel imports --

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

It is a new element -- it is more an event than having really a massive input. But, yes, necessarily now also, and in the future, importation from the new member states will raise the issue but the majority of importations today, of course, comes from the large markets such as France or Italy or Spain.

Alexandra Hauber - Bear, Stearns - Analyst

But can I -- sorry, can I just follow up on the eastern -- because we were all told when new countries were joining that their prices in the eastern countries were actually, largely, even higher than in the existing EU countries. So is it, again, a specific large product, which is affecting that, which causes that mean dynamic?

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

I would say it depends on the product. You see, overall we can say that we have relatively -- Sanofi-Aventis we have relatively high prices in eastern European countries, but with exceptions. And the market of importation is a highly selective market. If they find a product, which is less expensive in a very small -- let's say in Lithuania, they buy in this market and they open a new door, which does not change the overall statement that are our prices in Eastern Europe for the time being are relatively comfortable in this respect.

Now, as far as price cut is concerned, the price cut we have for Plavix to place not in Germany, but in France and the price cut has been 5%.

Now the depression of prescription in Germany on Plavix is a result of the overall growing pressure from the German authorities on doctors to become more and more limited in prescribing, so far, high price products. And given the fact that Clopidogrel is both products, [Eostrovere] and Plavix in Germany is the leading pharmaceutical product of the total market, we are suffering more. And yes, evidently, daily treatment and cost of Plavix is relatively high.

Then last, but not least, what I tried to say when I said we are more exposed with 18% market share than anybody else in France. I think yes, it's clear, if you have 18% market share you take more blows than you have sweetness in market share. But perhaps more importantly, we have approached [Feuer] in France with more than 100 products, which go from antibiotics over [inaudible] in to cardiovascular via oncology, we are more or less everywhere.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

And the interventions of the French government during this year, have been going into each and every market segment and they've brought a variety of interventions, which means taxes, price reductions, reference prices. So, yes, we see the kind of portfolio we have and the importance we have inside the French market, we are more exposed than anybody else and so, yes, necessarily, in quantitative terms we take more blows than anybody else.

Alexandra Hauber - *Bear, Stearns - Analyst*

Okay. And the adaptation measures? When were the temporary sales forces --?

Unidentified Company Representative

I would say that in the U.S. we have already started at the end of 2005 and we terminated the first external sales force. And, we have since started with very beginning of course but they are under the impression of the Apotex event. In France and in Germany we have started let's say, during the last four to eight weeks and we are really at the beginning of our measures. And as I said will translate into true savings into 2007.

Alexandra Hauber - *Bear, Stearns - Analyst*

Okay. Thank you.

Sanjay Gupta - *Sanofi Aventis - VP, IR*

Okay. We have time for a couple of questions and then will be our conclusion.

Operator

Thank you. Our next question comes from Paul Mann of Deutsche Bank. Please go ahead.

Paul Mann - *Deutsche Bank - Analyst*

Hi. I've just got a couple of quick questions. Perhaps you could talk about the tax rate and then can you give us the tax figures on the Plavix royalties? And the tax rate seemed to go down slightly in the third quarter '06. What tax rates do you assume for the fourth quarter of this year and then, for the full year?

And then, secondly, just on Eloxatine, following up from Tim's earlier question. You said you've got two patents in the U.S. How do those patents differ from any patents you've got in Europe, i.e. the patents haven't really prevented generics entering the European market?

Hanspeter Spek - *Sanofi Aventis - EVP, Pharmaceutical Operations*

Your question was how do those patents differ?

Paul Mann - *Deutsche Bank - Analyst*

From any patents you may have in Europe that haven't seemed to prevent generics into the market.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

Well they differ in terms of time.

Paul Mann - Deutsche Bank - Analyst

Okay.

Hanspeter Spek - Sanofi Aventis - EVP, Pharmaceutical Operations

The European patents comes to their end in 2006/2007 in essence, whereas the U.S. patents come to their end in the 2010 and then after. So that's the major difference to the answer of that one. Right, go ahead.

Paul Mann - Deutsche Bank - Analyst

The other one's on the tax.

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Yes. Okay. On the tax. At the beginning of the year, I mentioned that the effective tax rate for 2006 should be around 30.7% of the before tax income. You've seen some difference during the year. The main difference is only -- was related to the tax rate of the capital gain made on the disposal of Exubera. For the rest we have smaller items, which may play a small role in a difference which you see in the quarter -- third quarter for example, the rate used to be 30.6% but all we know, as far as the ongoing operations are concerned, we maintain the 30.7% effective tax rate for the full year '06.

Paul Mann - Deutsche Bank - Analyst

And what tax rate should we assume for Plavix royalties?

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Oh, in France, remember that -- I am talking of the French situation, no? Only when you receive royalties the tax rate is 15%.

Paul Mann - Deutsche Bank - Analyst

And so, for the Q4, should tax -- tax should therefore go up I'm assuming quite a bit?

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

No, that doesn't make necessary differences. You know, you have to make a mix of royalties but also, to make a mix of the result and the tax associated in the United States. So, the answer might not be the one you believe. It may not be such different that the effective tax rate of the country.

Oct. 31. 2006 / 2:00AM, SNY - Q3 2006 Sanofi-Aventis Earnings Conference Call

Paul Mann - Deutsche Bank - Analyst

Okay. Thanks very much.

Sanjay Gupta - Sanofi Aventis - VP, IR

I think we're pretty much at the end of our allotted time. Before we go, Jean-Claude would like to make a concluding statement, Mr. Spek.

Jean-Claude Leroy - Sanofi Aventis - EVP & CFO

Yes, if I may conclude maybe with a more positive stance. I would have to comment. The first one, when revising the guidance we could be revisiting these guidances or revising upwards the guidance -- this -- another way around for you to understand. Let me say that when we are selling Plavix in the U.S. from now on, we're going to make some profit, which in turn explains why we said that the guidance would be at least +2%.

Another one and Hanspeter already mentioned it, during his presentation, is that fourth quarter, during the fourth quarter we will see an evolution of the sales on a comparable basis, which are going to show up much better than the three quarters we had during the '06 year. Well just because, first, the general application of these four products mainly Allegra in the U.S. will be again over on a comparable basis. And in addition to that, again, as Hanspeter mentioned that, we will have a very good quarter in the vaccine business, as accounted for to a less favorable figures during the third quarter.

Thank you very much for taking the time to listen to us.

Sanjay Gupta - Sanofi Aventis - VP, IR

Thank you. Bye-bye.

Operator

Thank you. Ladies and gentlemen that will conclude today's Sanofi-Aventis Group sales and earnings results third quarter 2006 conference call. Thank you for your participation. You may now disconnect.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2006, Thomson Financial. All Rights Reserved.

Exhibit V



sanofi aventis

Because health matters

Paris, October 31, 2006

First 9 months of 2006:
Sales growth of 2.6% on a comparable basis¹
Adjusted EPS growth of 15.0%, or 7.5% excluding selected items³

The consolidated income statement for the first 9 months of 2006 is provided in the appendices. Consolidated net income after minority interests for the period was €3,431 million, compared with €1,802 million for the first 9 months of 2005, after the impact of the accounting treatment of acquisitions (primarily the acquisition of Aventis) and restructuring costs (€2,232 million after tax in 2006 and €3,089 million in 2005).

In order to give a better representation of our underlying economic performance, we have decided to publish and explain an adjusted consolidated income statement¹ for the first 9 months of 2006 and the third quarter of 2006, and to compare them with an adjusted consolidated income statement for the first 9 months and third quarter of 2005 respectively. Adjusted net income for the first 9 months of 2006 was €5,663 million, compared with €4,891 million for the first 9 months of 2005.

Unless otherwise indicated, all sales growth figures in this press release are stated on a comparable basis¹.

THIRD QUARTER:

- Third quarter of 2006 hit by the launch of a generic version of clopidogrel bisulfate in the United States on August 8, 2006, and by measures to curb healthcare costs in France and Germany.
- Net sales: €6,901 million, down 1.1% (down 4.2% on a reported basis). Excluding the impact of the introduction of generics of 4 products² in the United States, sales growth would have been 3.4%.
- Increase of 8.4% in R&D expenses.
- **Adjusted EPS of €1.26 (down 12.5%), or €1.26 (down 7.4%) excluding selected items³.**

FIRST 9 MONTHS:

- Net sales: €21,017 million, up 2.6% (up 3.5% on a reported basis). Excluding the impact of the introduction of generics of 4 products² in the United States, sales growth would have been 8.1%.
- Increase of 11.2% in R&D expenses.
- **Adjusted EPS of €4.21 (up 15.0%), or €3.87 (up 7.5%) excluding selected items (in particular the gain on the disposal of Exubera®).**

ACOMPLIA® LAUNCHED IN 7 EUROPEAN COUNTRIES

2006 GUIDANCE

Barring major adverse events, the Group anticipates adjusted EPS growth of at least 2% for the full year 2006 (page 13).

¹ Refer to the Appendices for definitions of financial indicators

² Excluding net sales in the United States of Allegra®, Amaryl®, Arava® and DDAVP® (generics introduced in the second half of 2005)

³ Refer to Appendix 5

Press Release

2006 third-quarter and 9-month net sales

In the third quarter of 2006, sanofi-aventis recorded net sales of €6,901 million, a fall of 1.1%. Exchange rate movements (relating mainly to the U.S. dollar) had an unfavorable effect of 2.4 points. Changes in Group structure had a negative effect of 0.7 of a point. On a reported basis, net sales fell by 4.2%.

In the 9 months to end September 2006, net sales rose by 2.6% to €21,017 million. Exchange rate movements (relating mainly to the U.S. dollar) had an favorable effect of 1.6 points. Changes in Group structure had a negative effect of 0.7 of a point. On a reported basis, net sales rose by 3.5%.

Net sales by business segment

Net sales reported by sanofi-aventis comprise net sales generated by the pharmaceuticals business and net sales generated by the human vaccines business.

Pharmaceuticals

Third-quarter net sales for the pharmaceuticals business, which were hit hard by the introduction of generics of 4 products⁴ in the United States and the effect of healthcare system reforms in France and Germany, fell by 0.4% to €6,254 million. Net sales of the top 15 products advanced by 1.5% to €4,221 million, representing 67.5% of pharmaceuticals net sales, against 66.2% for the comparable period in 2005.

Excluding the impact of generics of Allegra® and Amaryl® in the United States, the top 15 products would have achieved growth of 8.3% in the third quarter and 12.8% to end September.

In the 9 months to end September, net sales for the pharmaceuticals business totaled €19,290 million, up 1.3%. Net sales of the top 15 products rose by 5.0% to €12,868 million, representing 66.7% of pharmaceuticals net sales versus 64.4% for the comparable period in 2005.

€ million	Q3 2006 net sales	Change on a comparable basis	2006 9-month net sales	Change on a comparable basis
Lovenox®	583	+9.2%	1,821	+13.2%
Plavix®	543	+2.5%	1,688	+11.2%
Stilnox®/Ambien®/Ambien CR™	538	+33.8%	1,446	+29.9%
Taxotere®	429	+5.1%	1,315	+9.0%
Eloxatin®	417	+1.7%	1,291	+11.1%
Lantus®	412	+30.8%	1,215	+37.3%
Copaxone®	262	+12.4%	796	+20.4%
Aprovel®	252	+13.0%	750	+12.4%
Tritace®	223	-13.9%	706	-5.1%
Allegra®	156	-55.4%	525	-56.8%
Amaryl®	106	-43.9%	346	-36.7%
Xatral®	83	+5.1%	269	+12.1%
Actonel®	84	0.0%	264	+9.5%
Depakine®	73	-7.6%	227	-5.0%
Nasacort®	60	-3.2%	209	-1.9%
TOTAL TOP 15	4,221	+1.5%	12,868	+5.0%
TOTAL TOP 15 excl. impact Allegra® and Amaryl® in the USA *	4,120	+8.3%	12,565	+12.8%

* Excluding net sales of Allegra® and Amaryl® in the United States

⁴Allegra®, Amaryl®, Arava®, DDAVP®

Third-quarter net sales of other pharmaceutical products fell by 4.3% to €2,033 million. Excluding the impact of generics of DDAVP® and Arava® in the United States⁵, net sales of other pharmaceutical products would have fallen by 2.1%.

In the 9 months to end September, net sales of other pharmaceutical products fell by 5.4% to €6 422 million. Excluding the impact of generics of DDAVP® and Arava® in the United States⁵, net sales of other pharmaceutical products would have fallen by 2.5%.

Human Vaccines

Third-quarter consolidated net sales for the human vaccines business fell by 7.0% to €647 million. The decline in sales during the quarter reflected the postponement to the fourth quarter of shipments of influenza vaccines in the United States, with production of the vaccine delayed by the changeover of two strains and by low yields in the initial production phase for one of these strains. Our objective of shipping 50 million doses of Fluzone® in the United States in 2006 is unchanged.

Menactra® recorded net sales of €78 million in the third quarter and €197 million in the 9 months to end September.

Sales of Adacel™ (adult tetanus-diphtheria-whooping cough booster), launched in the United States in July 2005, reached €46 million in the third quarter and €124 million in the 9 months to end September. A new production facility was approved by the FDA in August 2006 and is expected to be operational by the end of the year, making it easier for us to meet demand for certain whooping cough vaccines from 2007 onwards.

In the first 9 months of 2006, consolidated net sales for the human vaccines business were €1,727 million, an increase of 19.6%.

€ million	Q3 2006 net sales	Change on a comparable basis	2006 9-month net sales	Change on a comparable basis
Polio/Whooping Cough/Hib Vaccines	172	+17.0%	492	+16.0%
Adult Booster Vaccines	83	-3.5%	261	+20.8%
Influenza Vaccines	172	-35.3%	396	+18.6%
Travel Vaccines	67	+42.6%	191	+45.8%
Meningitis/Pneumonia Vaccines	102	-3.8%	253	+21.1%
Other vaccines	51	15.9%	134	+3.1%
TOTAL	647	-7.0%	1,727	+19.6%

Third-quarter sales at Sanofi Pasteur MSD, the joint venture with Merck & Co in Europe, fell by 26.6% on a reported basis to €181 million. Excluding Hexavac®, suspended by the EMEA in September 2005, Sanofi Pasteur MSD would have recorded a 21.9% decline in net sales on a reported basis. This drop in sales was due mainly to the postponement to the fourth quarter of shipments of the Vaxigrip influenza vaccine.

In September, Gardasil® (a product developed by Merck & Co) was approved in the European Union for use in prevention of high grade cervical dysplasia (CIN 2/3), cervical carcinoma, high grade vulvar dysplastic lesions (VIN 2/3), and external genital warts caused by human papillomavirus (HPV) types 6, 11, 16 and 18. Marketing of the product has already begun in Austria, Germany, Finland, Sweden, the United Kingdom and Ireland. The product is due to be launched in France by the end of the year.

⁵ Excluding net sales of Arava® and DDAVP® in the United States

Two other vaccines developed by Merck & Co, which are to be marketed by Sanofi Pasteur MSD, were also approved recently by the European authorities:

- Zostavax®, a vaccine against herpes zoster (shingles) and herpes zoster related postherpetic neuralgia, was approved in May (frozen form); an application for approval of a refrigerated form was submitted in July 2006.

- Rotateq® was approved in June for the prevention of pediatric rotavirus gastroenteritis.

In the 9 months to end September, Sanofi Pasteur MSD posted sales of €467 million, down 11.4%. Excluding Hexavac®, the joint venture's sales would have remained stable on a reported basis.

These sales are not consolidated by sanofi-aventis.

Net sales by geographical region

€ million	Q3 2006 net sales	Change on a comparable basis	2006 9-month net sales	Change on a comparable basis
Europe	2,927	-2.0%	9,157	+1.2%
United States	2,464	-5.0%	7,305	+0.2%
Other countries	1,510	+8.2%	4,555	+9.9%
TOTAL	6,901	-1.1%	21,017	+2.6%

In Europe, third-quarter net sales fell by 2.0%, having been heavily impacted by healthcare system reforms in France and Germany.

The German reforms, especially the pressure on doctors to curb prescriptions, led to a marked deceleration in the pharmaceutical market and on sanofi-aventis local sales during the third quarter. In addition, some of our products were particularly affected by parallel imports.

In the 9 months to end September, net sales in Europe rose by 1.2%.

In the United States, net sales were affected by competition from generics of 4 products². Third-quarter net sales fell by 5.0%, while net sales for the 9 months to end September showed a slight increase of 0.2%.

Excluding the impact on net sales of these 4 products², third-quarter sales growth would have been 7.7%, with the growth rate affected notably by the postponement of shipments of the Fluzone® influenza vaccine. In the 9 months to end September, excluding the impact of the same 4 products² in the United States, net sales would have risen by 17.3%.

Growth in "Other Countries" reached 8.2% in the third quarter and 9.9% in the 9 months to end September. Latin America and Asia continue to post strong growth.

Developed sales¹

Developed sales give an indication of the overall presence of sanofi-aventis products in the market. Third-quarter developed sales were €7,537 million, a drop of 4.0%, reflecting the situation of Plavix® in the United States (see comments on developed sales of Plavix®). In the 9 months to end September, developed sales rose by 2.8% to €23,638 million.

Developed sales of Plavix®/Iscover®:

€ million	Q3 2006	Change on a comparable basis	2006 9 months	Change on a comparable basis
Europe	420	+3.7%	1,279	+10.0%
United States	377	-42.4%	1,894	+0.7%
Other countries	175	+16.7%	519	+19.0%
TOTAL	972	-19.7%	3,692	+6.1%

On August 8, 2006, Apotex announced that it had launched a generic version of clopidogrel bisulfate 75 mg tablets in competition with Plavix®. On August 31, 2006, the U.S. District Court for the Southern District of New York granted the motion filed by sanofi-aventis and Bristol-Myers Squibb for a preliminary injunction and ordered Apotex to halt sales of its generic version of clopidogrel bisulfate. However, the Court did not order the recall of products already sold by Apotex.

As a result, sales of Plavix® in the United States were hit hard during the third quarter, falling by 42.4% to €377 million, of which €67 million was recorded after August 8. However, growth in total prescriptions (TRx) of clopidogrel bisulfate remained strong at 12.7%⁶ in the third quarter and 13.4%⁷ in the 9 months to end September.

In August 2006, the Food and Drug Administration approved a new indication for Plavix® in patients suffering from acute ST-segment elevation myocardial infarction, to reduce the rate of death from any cause and the rate of a combined endpoint of re-infarction, stroke or death. The same indication was approved in the European Union in September.

In Europe, third-quarter net sales of Plavix® rose by 3.7% to €420 million. This low rate of growth was largely due to a decline in sales in Germany, reflecting a marked slowdown in the local market.

In Japan, the launch of Plavix® as a treatment for the reduction of recurrence after ischemic cerebrovascular disorder continued, subject to the conditions imposed by the Japanese authorities (6-month Post-Marketing Vigilance Period, and prescriptions limited to a maximum of two weeks for a 12-month period).

⁶ IMS NPA 3 channels-Q3 2006

⁷ IMS NPA 3 channels- YTD end September 2006

Developed sales of Aprovel®/Avapro®/Karvea®:

€ million	Q3 2006	<i>Change on a comparable basis</i>	<i>2006 9 months</i>	<i>Change on a comparable basis</i>
Europe	214	+8.1%	649	+10.8%
United States	126	+8.6%	378	+15.6%
Other countries	95	+14.5%	272	+14.3%
TOTAL	435	+9.6%	1,299	+12.9%

Third-quarter developed sales of Aprovel®/Avapro®/Karvea® were up 9.6% at €435 million.

In the United States, the product posted 8.6% net sales growth in the third quarter. Prescriptions (TRx) rose by 3.2%⁶ in the quarter. Total prescriptions of the product in the 9 months to end September rose by 4.4%⁷.

Comments by product

Geographical split of consolidated net sales by product (Top 15)

Q3 2006 net sales (€ million)	Europe	Change on a comparable basis	USA	Change on a comparable basis	Other countries	Change on a comparable basis
Lovenox®	164	+3.8%	358	+11.9%	61	+8.9%
Plavix®	391	+3.7%	41	-38.8%	111	+29.1%
Stilnox®/Ambien®/Ambien CR™	24	-11.1%	489	+37.4%	25	31.6%
Taxotere®	174	+7.4%	174	+0.6%	81	+11.0%
Eloxatin®	144	+2.1%	234	0.0%	39	+11.4%
Lantus®	131	+22.4%	244	+33.3%	37	+48.0%
Copaxone®	71	+20.3%	177	+9.9%	14	+7.7%
Aprovel®	197	+9.4%	-	-	55	+27.9%
Tritace®	117	-15.8%	3	-	103	-13.4%
Allegra®	10	0.0%	97	-66.8%	49	+2.1%
Amaryl®	38	-43.3%	4	-93.4%	64	+4.9%
Xatral®	45	-19.6%	25	+92.3%	13	+30.0%
Actonel®	57	-3.4%	-	-	27	+8.0%
Depakine®	52	-13.3%	-	-	21	+10.5%
Nasacort®	8	+14.3%	46	-6.1%	6	0.0%

2006 9-month net sales (€ million)	Europe	Change on a comparable basis	USA	Change on a comparable basis	Other countries	Change on a comparable basis
Lovenox®	515	+6.2%	1,123	+16.6%	183	+14.4%
Plavix®	1,202	+10.2%	151	-12.2%	335	+31.4%
Stilnox®/Ambien®/Ambien CR™	72	-11.1%	1,306	+34.5%	68	+11.5%
Taxotere®	536	+15.8%	534	+0.9%	245	+14.5%
Eloxatin®	440	+8.9%	730	+9.3%	121	+34.4%
Lantus®	386	+29.1%	729	+38.6%	100	+66.7%
Copaxone®	207	+21.8%	547	+21.0%	42	+7.7%
Aprovel®	595	+10.2%	-	-	155	+22.0%
Tritace®	387	-9.4%	13	+160.0%	306	-1.9%
Allegra®	43	0.0%	291	-69.3%	191	-15.5%
Amaryl®	141	-27.7%	12	-93.2%	193	+10.3%
Xatral®	165	-4.6%	67	+86.1%	37	+19.4%
Actonel®	185	+8.2%	-	-	79	+12.9%
Depakine®	158	-10.7%	-	-	69	+11.3%
Nasacort®	32	+10.3%	156	-4.3%	21	0.0%

Net sales of **Lovenox®**, the leading low molecular weight heparin on the market, reached €583 million in the third quarter, a rise of 9.2%. Growth of the product continues to be driven by its increasing use in medical prophylaxis. Sales in Europe rose by 3.8%, with the growth rate adversely affected by a decline in German sales of the product. In the 9 months to end September, net sales of Lovenox® advanced by 13.2%.

Filing for approval of Lovenox® as a treatment for patients suffering from acute ST-segment elevation myocardial infarction (ExTRACT study) is due to take place in the fourth quarter in both Europe and the United States. This new indication is expected to further enhance the superiority of Lovenox over non-fractionated heparins.

The results of the PREVAIL study, evaluating the benefits of Lovenox® in the prevention of deep vein thrombosis after ischemic cerebrovascular events, are due to be presented to the American Society of Hematology in December 2006.

In addition to the decline in sales in Germany consolidated net sales of **Plavix®** were hit by the launch of a generic version of clopidogrel bisulfate 75 mg tablets in the United States. Sales of Plavix® raw materials for shipment to the United States (consolidated by sanofi-aventis) fell by 38.8% in the quarter, to €41 million. Excluding this effect, Plavix® would have recorded 8.4% growth in the quarter.

Net sales of **Ambien®/Ambien CR™** in the United States rose by 37.4% in the quarter to €489 million. The product had a market share of 45.2%⁸ at the end of September, versus 44.7% at the end of June (IMS NPA-3 channels). To end September, prescriptions of Ambien CR™ represented some 27% of prescriptions of Ambien® brand products.

The pediatric dossier for Ambien® was submitted to the FDA on 29 September 2006.

In Japan, sales of Myslee® (developed sales) reached €84 million, an increase of 15.3%.

Taxotere® recorded third-quarter growth of 11.0% in "Other Countries" and 7.4% in Europe. In the United States, the product continues to gain market share as an adjuvant breast cancer treatment, despite a difficult competitive environment.

Taxotere® was recently approved in the United States and Europe for advanced stage gastric cancer in association with the standard treatment (cisplatin and 5-fluorouracil). On October 23, the European Commission has adopted the positive opinion of the Committee for Human Medicinal Products opinion (CHMP) of the European Medicines Agency (EMA) on the use in Europe of Taxotere® in combination with a classic regimen (cisplatin and 5-fluorouracil) as induction treatment for patients with inoperable locally advanced squamous cell carcinoma of the head and neck, also referred as head and neck cancer. This additional indication was approved in the United States on October 17.

The FDA has granted a pediatric extension for **Eloxatin®** in the United States, extending the data protection period by six months until February 2007. It also extends other regulatory exclusivity periods by 6 months.

To further strengthen its portfolio in oncology, on July 3 sanofi-aventis announced it had signed an agreement with the Japanese pharmaceutical company Taiho giving sanofi-aventis the rights to develop and market the oral anticancer agent S-1, a new proprietary oral derivative of fluorouracil from Taiho. Sanofi-aventis will lead the development and marketing of the product worldwide, except in Japan and some other Asian countries. Taiho will be involved in the development of the product and will have the option of participating in the promotion of the product in any country in which sanofi-aventis markets it.

On October 13, Taiho and sanofi-aventis announced that, based on the recommendations of the Steering Committee of a study conducted by Taiho to assess the S-1 oral anticancer agent as an adjuvant gastric cancer treatment after surgery, the interim efficacy analysis demonstrated superior clinical benefits in the S-1 arm of the study.

⁸ IMS NPA 3 channels – September 2006

Lantus®, the world's leading insulin brand, continues to show excellent performances, with net sales up 30.8% in the third quarter to €412 million. In the 9 months to end September, the product posted net sales of €1,215 million, up 37.3%. The new disposable pen, **Solostar®**, was approved in Europe in September, and the application is currently under review in the United States. The first launches of **Solostar®** are scheduled for the final quarter of 2006.

Acomplia®, initially launched at end June in the United Kingdom, is now available in Germany, Denmark, Norway, Finland, Austria and Ireland. Third-quarter net sales totaled €11 million. Two months after its launch in the United Kingdom, the product is getting very positive feedback from specialists and general practitioners treating obese patients with cardiometabolic risk factors.

In Denmark, **Acomplia®** is reimbursable, subject to prior authorization, for patients with a Body Mass Index of more than 27 with life-threatening obesity-related conditions such as type 2 diabetes or dyslipidemia (low levels of HDL cholesterol plus hypertriglyceridemia) who fail to respond adequately to a weight-loss diet. In Ireland, **Acomplia®** will be reimbursed without restriction in its approved indications by the Department of Health & Children from November 1, 2006.

On October 18, the German Federal Joint Committee ("Gemeinsamer Bundesausschuss" – "G-BA") announced that it had recommended classifying **Acomplia®** under Section 34 of the Social Code Volume V ("Sozialgesetzbuch Bd. V" – "SGB V"). Section 34 covers products viewed as lifestyle medications which are currently not reimbursed by German statutory health insurance ("Gesetzliche Krankenkasse"). This decision is pending final ratification by the Ministry of Health within a period of two months. It becomes legally binding after publication in the Official Journal of the Government ("Bundesanzeiger"). Sanofi-aventis regards this classification as not only unjustified on public health policy grounds, but also as unlawful. If the G-BA decision were to be ratified, sanofi-aventis intends to challenge the decision to refuse reimbursement under Section 34 in the courts.

The results of the SERENADE trial evaluating rimonabant in type II diabetes patients not receiving treatment will be presented at the World Diabetes Foundation in December 2006.

Regarding the ongoing review of rimonabant® in the United States, the company has submitted on October 26, 2006 the complete response to the approvable letter received from the FDA on February 17, 2006.

Adjusted consolidated income statement (unaudited)

The adjusted consolidated income statement is presented in Appendix 3.

Refer to Appendix 1 for a definition of "adjusted net income", and to Appendix 4 for a reconciliation of the consolidated income statement to the adjusted consolidated income statement.

Third quarter of 2006

Net sales generated by sanofi-aventis in the third quarter of 2006 fell by 4.2% on a reported basis to €6,901 million.

Gross profit was €5,302 million. The gross margin ratio was 76.8%, against 78.7% in the comparable period of 2005. This reduction was mainly due to two factors:

- A 1 percentage point increase (to 26.7%) in the ratio of cost of sales to net sales, due to generics of Allegra®, Amaryl®, Arava® and DDAVP®. The third-quarter ratio was in line with that for the first half of 2006.
- A 24.2% decline in other revenues (€241 million) due to the marked drop in royalties generated by Plavix® in the United States.

Research and development expenses continued their increase in the third quarter, and were 8.4% higher than in the third quarter of 2005 at €1,075 million. As in the first half of 2006, this rise reflects increasing Phase III clinical trials activity in pharmaceuticals and greater investment in R&D in the vaccines business. Research and development expenses represented 15.6% of net sales, against 13.8% in the third quarter of 2005.

Selling and general expenses were 10.5% lower than in the third quarter of 2005 at €1,806 million, equivalent to 26.2% of net sales. During the quarter, there was a slowdown in selling expenses in the United States, Germany and France as sanofi-aventis adapted to the changing market environment. There was a further marked reduction in general expenses.

Other current operating income and expenses totaled €96 million, compared with €29 million in the third quarter of 2005. This improvement was due to foreign exchange differences, which showed a net gain of €27 million compared with a net loss of €50 million in 2005.

Operating income – current was down 6.5% at €2,481 million, and represented 36.0% of net sales as opposed to 36.8% in the third quarter of 2005.

Operating income was down 7.7% at €2,479 million.

Net financial expense was €53 million, against €19 million for the third quarter of 2005, when sanofi-aventis recorded a gain of €64 million on the disposal of various holdings (mainly Transkaryotic and Viropharma).

Interest expense on debt came to €92 million, compared with €104 million in the third quarter of 2005.

Income tax expense was €743 million, against €829 million in the third quarter of 2005. The effective tax rate was 30.6%, versus 31.1% in the comparable period of 2005.

The **share of profits from associates** was €116 million, compared with €175 million in the third quarter of 2005. This item was hit by the situation affecting Plavix® in the United States, and reflects the decline in the share of after-tax profits from territories managed by BMS (primarily the United States) under the Plavix® and Avapro® alliance (€56 million, versus €112 million in the third quarter of 2005).

Minority interests totaled €100 million, against €91 million in the third quarter of 2005. This line includes the share of pre-tax profits paid over to BMS from territories managed by sanofi-aventis (€95 million, versus €82 million in the third quarter of 2005).

Adjusted net income was down 11.6% at €1,699 million.

After excluding selected items, adjusted net income was also €1,699 million, down 6.6% on the 2005 third-quarter figure of €1,819 million (see Appendix 5).

Adjusted earnings per share (EPS) was €1.26, 12.5% lower than the 2005 third-quarter figure of €1.44, based on an average number of shares outstanding of 1,348.0 million in the third quarter of 2006 and 1,337.1 million in the third quarter of 2005.

After excluding selected items, adjusted EPS was also €1.26, 7.4% lower than the 2005 third-quarter figure of €1.36 (see Appendix 5).

First 9 months of 2006

Net sales generated by sanofi-aventis in the first 9 months of 2006 were €21,017 million, an increase of 3.5% on a reported basis.

Gross profit was €16,307 million, 2.6% higher than in the first 9 months of 2005. The gross margin ratio was 77.6%, versus 78.3% in the comparable period of 2005. The ratio of cost of sales to net sales increased by just 0.6 of a point to 26.6%, due to the impact of generics of Allegra®, Amaryl®, Arava® and DDAVP® in the United States. Other revenues rose by only 2.5% (€888 million) in the first 9 months of the year, affected by the significant decline in royalties generated by Plavix® in the United States in the third quarter.

Research and development expenses were 11.2% higher than in the first 9 months of 2005 at €3,219 million, representing 15.3% of net sales (versus 14.3% in the 9 months to end September 2005).

Selling and general expenses were 1.7% down on the first 9 months of 2005 at €5,867 million, equivalent to 27.9% of net sales. Selling expenses were virtually unchanged year on year due to the reduction in the third quarter, while general expenses were lower than in the comparable period of 2005.

Other current operating income and expenses totaled €236 million, against €98 million on the 9 months to end September 2005. This line includes the income generated by the agreement with Prasco on the marketing of authorized generics in the United States. Net foreign exchange differences were neutral in the first 9 months of 2005, compared with a net loss of €44 million in the comparable period of 2005.

Operating income – current advanced by 4.3% to €7,355 million, and represented 35.0% of net sales, an improvement of 0.3 of a point on the first 9 months of 2005.

Other operating income and expenses totaled €520 million, compared with €44 million in the first 9 months of 2005. This line includes gains on disposals of €548 million, of which €460 million (€384 million after tax) related to Exubera® and €45 million to the sale of the residual 30% interest in an Animal Nutrition business.

Operating income was up 11.5% at €7,872 million.

Net financial expense came to €146 million, compared with €224 million in the comparable period of 2005. The reduction in net financial expense was mainly attributable to a reduction in debt due to the cash flow generated by sanofi-aventis. Interest expense on debt was €250 million, versus €339 million in the first 9 months of 2005.

Net financial expense was also helped by gains on financial instruments (€50 million, versus €32 million in the first 9 months of 2005).

Income tax expense was €2,282 million, compared with €2,131 million for the first 9 months of 2005, giving an effective tax rate of 29.5%, against 31.2% for the first 9 months of 2005. Excluding the gain on Exubera®, the effective tax rate for the 9 months to end September 2006 was 30.3%.

The **share of profit from associates** totaled €509 million, compared with €444 million in the 9 months to end September 2005. This line includes the share of after-tax profits from territories managed by BMS (primarily the United States) under the Plavix® and Avapro® alliance (€308 million, compared with €295 million in the first 9 months of September 2005), which in the third quarter was hit by the situation affecting Plavix® in the United States.

There was a significant increase in the contribution from Merial in the 9 months to end September 2005.

Minority interests amounted to €290 million, compared with €261 million in the first 9 months of 2005. This line includes the share of pre-tax profits paid over to BMS from territories managed by sanofi-aventis (€277 million, versus €220 million in the 9 months to end September 2005).

Adjusted net income was up 15.8% at €5,663 million.

Excluding selected items, **adjusted net income** was €5,203 million, 8.2% higher than the €4,807 million posted in the first 9 months of 2005 (see Appendix 5).

Adjusted earnings per share (EPS) came to €4.21, 15.0% up on the 2005 9-month figure of €3.66, based on an average number of shares outstanding of 1,346.1 million for the first 9 months of 2006 and 1,335.8 million for the comparable period of 2005.

Excluding selected items, **adjusted EPS** was €3.87, 7.5% higher than the 2005 9-month figure of €3.60 (see Appendix 5).

Consolidated net debt

Consolidated net debt, which stood at €8.8 billion at June 30, 2006, amounted to €7.4 billion at September 30, 2006; this represented an improvement of €2.5 billion relative to December 31, 2005. Gearing stood at 16.0% at end September 2006, compared with 19.5% at end June 2006 and 21.4% at end December 2005.

2006 FULL-YEAR GUIDANCE

Sanofi-aventis does not have knowledge about the quantity of generic clopidogrel remaining in the supply chain in the United States at end September 2006. Consequently, although some sales of Plavix® have been recorded since August 8 (€67 million from August 8 through September 30), it is not possible to extrapolate these figures over the fourth quarter.

The above along with other information currently available to the company leads it to anticipate, barring major adverse events, adjusted EPS growth of at least 2% for the full year 2006:

- taking into account the effect on 2006 adjusted net income of Apotex's pre-injunction sales of a generic clopidogrel bisulfate product, assumed to be in sufficient quantities to satisfy substantially all U.S. market demand through the end of 2006;
- taking into account the full-year impact of the availability of generics of Allegra®, Amaryl®, Arava® and DDAVP® in the United States;
- taking into account the substantial launch costs of Plavix® in Japan and rimonabant;
- assuming selected items of €300 million, compared to after-tax selected items of €168 million in 2005; and
- based on an exchange rate of €1:\$1.25, with sensitivity to the euro/dollar exchange rate estimated at 0.6% of growth for a 1-cent movement in the exchange rate.

Forward-Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expect", "anticipates", "believes", "intends", "estimates", "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

Recent Events

August 8, 2006	Update on the Plavix® patent infringement suit brought by sanofi-aventis and Bristol-Myers Squibb against Apotex
August 17, 2006	New indication for Plavix® approved by the FDA, and new therapeutic option for the most severe form of myocardial infarction
August 31, 2006	Non approvable letter from the FDA for dronedarone in the treatment of atrial fibrillation/atrial flutter. A new filing is expected in the United States in the first half of 2008 based on the data from the ongoing ATHENA study.
August 31, 2006	Announcement that the U.S. District Court for the Central District of California had set a revised trial date of December 4, 2006 for the separate trial on intent issues in the Lovenox® patent infringement case against Amphastar and Teva.
August 31/ September 1, 2006	Announcement that the U.S. District Court for the Southern District of New York granted the motion filed by sanofi-aventis and Bristol-Myers Squibb for a preliminary injunction and ordered Apotex Inc. and Apotex Corp. to halt sales of their generic version of clopidogrel bisulfate that competes with Plavix®. However, the Court did not order the recall of products already sold or shipped.
September 1, 2006	Update to 2006 guidance.
September 7, 2006	Announcement of the withdrawal of the European application for marketing authorization in the treatment of atrial fibrillation/atrial flutter. A new filing is expected in the first half of 2008.
September 7, 2006	Authorization of a new indication for Plavix® to include patients with ST-segment elevation acute myocardial infarction who are eligible for thrombolytic therapy.
September 13, 2006	Announcement of the ruling by the arbitration tribunal in the arbitration proceedings against Rhodia. The tribunal rejected Rhodia's claim for compensation on environmental matters, and declared that it did not have jurisdiction to rule on pensions issues.
September 19, 2006	Announcement by Sanofi Pasteur of the first clinical trial of a new cell culture based H7N1 vaccine
September 21, 2006	Denial by the United States Court of Appeals for the Federal Circuit of the motion by Apotex to stay the August 31, 2006 preliminary injunction issued by the United States District Court for the Southern District of New York. The Court set an expedited schedule for Apotex's appeal of the preliminary injunction, with oral argument scheduled for October 31, 2006.
September 22, 2006	Positive opinion of the Committee for Human Medicinal Products (CHMP) for Taxotere® as a head and neck cancer treatment in the European Union.
September 25, 2006	Signature of a co-promotion agreement with UCB for Xyzal® in the United States.
October 13, 2006	Announcement by Taiho and sanofi-aventis of a positive interim outcome from a study evaluating S-1 as an adjuvant treatment for gastric cancer.
October 17, 2006	Sanofi-aventis sold its entire stake in the capital of Rhodia representing 96,110,182 shares, for a total consideration of €183 million.
October 18, 2006	Announcement of FDA approval of Taxotere® as a treatment for patients with head and neck cancer

Financial Timetable

February 13, 2007	2006 results – Analyst/Investor meeting in Paris
May 3, 2007	2007 first-quarter sales and results
May 31, 2007	Shareholders' Annual General Meeting
August 1, 2007	2007 second-quarter sales and results
October 31, 2007	2007 third-quarter sales and results

Appendices

List of appendices

- Appendix 1: Explanatory notes
- Appendix 2: 2006 third-quarter and 9-month net sales by product
- Appendix 3: 2006 third-quarter and 9-month adjusted consolidated financial statements (unaudited)
- Appendix 4: 2006 third-quarter and 9-month reconciliations of consolidated income statement to adjusted consolidated income statement (unaudited)
- Appendix 5: Trends in selected adjusted income statement items

Appendix 1: Explanatory notes

Comparable net sales

When we refer to the change in our sales on a "comparable" basis, we mean that we exclude the impact of exchange rate movements and changes in Group structure (acquisitions and divestments of interests in entities and rights to products, and changes in consolidation method for consolidated entities).

We exclude the impact of exchange rates by recalculating sales for the prior period on the basis of exchange rates used in the current period. We exclude the impact of acquisitions by including sales from the acquired entity or product rights for a portion of the prior period equal to the portion of the current period during which we owned them, based on sales information we receive from the party from whom we make the acquisition.

Similarly, we exclude sales in the relevant portion of the prior period when we have sold an entity or rights to a product.

For a change in consolidation method, the prior period is recalculated on the basis of the method used for the current period.

Reconciliation of 2005 third-quarter net sales to 2005 third-quarter comparable net sales

€ million	Q3 2005
Q3 2005 net sales	7,200
Impact of changes in Group structure	(46)
Impact of exchange rates	(177)
Q3 2005 comparable net sales	6,977

Reconciliation of 2005 9-month net sales to 2005 9-month comparable net sales

€ million	2005: 9 months
2005 9-month net sales	20,304
Impact of changes in Group structure	(136)
Impact of exchange rates	321
2005 9-month comparable net sales	20,489

Developed sales

When we refer to “developed sales” of a product, we mean our consolidated net sales minus sales of products to our alliance partners plus non-consolidated sales made through our alliances with Bristol-Myers Squibb on Plavix®/Iscover® (clopidogrel) and Aprovel®/Avapro®/Karvea® (irbesartan) and Fujisawa on Stilnox®/Myslee® (zolpidem). Our alliance partners provide us with information regarding their sales in order to allow us to calculate developed sales.

We believe that developed sales are a useful measurement tool because they demonstrate trends in the overall presence of our products in the market.

Reconciliation of net sales to developed sales.

€ million	Q3 2006
Net sales	6,901
Non-consolidated sales of Plavix®/Iscover®, net of sales of product to BMS	429
Non-consolidated sales of Aprovel®/Avapro®/Karvea®, net of sales of product to BMS	183
Non-consolidated sales of Stilnox®/Myslee®, net of sales of product to Fujisawa	24
Developed sales	7,537

€ million	2006: 9 months
Net sales	21,017
Non-consolidated sales of Plavix®/Iscover®, net of sales of product to BMS	2,004
Non-consolidated sales of Aprovel®/Avapro®/Karvea®, net of sales of product to BMS	549
Non-consolidated sales of Stilnox®/Myslee®, net of sales of product to Fujisawa	68
Developed sales	23,638

Adjusted net income

We define "adjusted net income" as accounting net income after minority interests (determined under IFRS) adjusted to exclude (i) the material impacts of the application of purchase accounting to acquisitions and (ii) acquisition-related integration and restructuring costs. Sanofi-aventis believes that eliminating these impacts from net income gives investors a better understanding of the underlying economic performance of the combined Group.

The material impacts of the application of purchase accounting to acquisitions, primarily the acquisition of Aventis, are as follows:

- Charges arising from the remeasurement of inventories at fair value, net of tax
- Amortization/impairment expense generated by the remeasurement of intangible assets, net of tax
- Any impairment charged against the goodwill arising on the acquisition

Sanofi-aventis also excludes from adjusted net income any integration and restructuring costs that are specific to the acquisition of Aventis by sanofi-aventis.

€ million	Q3 2006 Consolidated financial statements (unaudited)	Q3 2006 Adjusted consolidated financial statements (unaudited)	2006: 9 months Consolidated financial statements (unaudited)	2006: 9 months Adjusted consolidated financial statements (unaudited)
Net sales	6,901	6,901	21,017	21,017
Net income*	1,050	1,699	3,431	5,663
Basic EPS	0.78	1.26	2.55	4.21

* After minority interests

Appendix 2: 2006 third-quarter and 9-month net sales by product**2006 third-quarter net sales by product:**

€ million	Q3 2006 net sales	Q3 2005 comparable net sales	Q3 2005 reported net sales
Lovenox®	583	534	551
Plavix®	543	530	534
Stilnox®/Ambien®/Ambien CR™	538	402	419
Taxotere®	429	408	420
Eloxatin®	417	410	422
Lantus®	412	315	325
Copaxone®	262	233	240
Aprovel®	252	223	225
Tritace®	223	259	260
Allegra®	156	350	367
Amaryl®	106	189	195
Xatral®	83	79	80
Actonel®	84	84	99
Depakine®	73	79	81
Nasacort®	60	62	65
TOTAL	4,221	4,157	4,283
Other products	2,033	2,124	2,200
TOTAL Pharmaceuticals	6,254	6,281	6,483
Vaccines	647	696	717
TOTAL net sales	6,901	6,977	7,200

2006 9-month net sales by product

€ million	2006 9-month net sales	2005 9-month comparable net sales	2005 9-month reported net sales
Lovenox®	1,821	1,608	1,571
Plavix®	1,688	1,518	1,508
Stilnox®/Ambien®/Ambien CR™	1,446	1,113	1,089
Taxotere®	1,315	1,206	1,184
Eloxatin®	1,291	1,162	1,141
Lantus®	1,215	885	869
Copaxone®	796	661	646
Aprovel®	750	667	661
Tritace®	706	744	724
Allegra®	525	1,216	1,185
Amaryl®	346	547	542
Xatral®	269	240	237
Actonel®	264	241	275
Depakine®	227	239	238
Nasacort®	209	213	206
TOTAL	12,868	12,260	12,076
Other products	6,422	6,785	6,809
TOTAL Pharmaceuticals	19,290	19,045	18,885
Vaccines	1,727	1,444	1,419
TOTAL net sales	21,017	20,489	20,304

Appendix 3: 2006 third-quarter and 9-month adjusted consolidated financial statements (unaudited)**2006 third-quarter adjusted consolidated financial statements (unaudited)**

€ million	Q3 2006 Adjusted consolidated income statement (unaudited)	as % of net sales	Q3 2005 Adjusted consolidated income statement (unaudited)	as % of net sales	% change
Net sales	6,901	100.0%	7,200	100%	-4.2%
Other revenues	241	3.5%	318	4.4%	-24.2%
Cost of sales	(1,840)	(26.7%)	(1,853)	(25.7%)	-0.7%
Gross profit	5,302	76.8%	5,665	78.7%	-6.4%
Research and development expenses	(1,075)	(15.6%)	(992)	(13.8%)	+8.4%
Selling and general expenses	(1,806)	(26.2%)	(2,018)	(28.0%)	-10.5%
Other current operating income	122	-	59	-	+106.8%
Other current operating expenses	(26)	-	(30)	-	-13.3%
Amortization of intangibles	(36)	-	(31)	-	+16.1%
Operating income – current	2,481	36.0%	2,653	36.8%	-6.5%
Restructuring costs	-	-	(3)	-	-
Impairment of PP&E and intangibles	(2)	-	0	-	-
Other operating income and expenses	-	-	37	-	-
Operating income	2,479	35.9%	2,687	37.3%	-7.7%
Financial expenses	(119)	-	(123)	-	-3.3%
Financial income	66	-	104	-	-36.5%
Income before tax and associates	2,426	35.2%	2,668	37.1%	-9.1%
Income tax expense	(743)	(10.9%)	(829)	(11.5%)	-10.4%
Effective tax rate	30.6%	-	31.1%	-	-
Share of profit/loss of associates	116	-	175	-	-33.7%
Consolidated net income	1,799	26.1%	2,014	28.0%	-10.7%
Minority interests	100	-	91	-	+9.9%
Net income after minority interests	1,699	24.6%	1,923	26.7%	-11.6%
Average number of shares outstanding (m)	1,348.0		1,337.1		
Earnings per share (in euros)	1.26		1.44		-12.5%

2006 9-month adjusted consolidated financial statements (unaudited)

€ million	2006: 9 months Adjusted consolidated income statement (unaudited)	as % of net sales	2005: 9 months Adjusted consolidated income statement (unaudited)	as % of net sales	% change
Net sales	21,017	100.0%	20,304	100%	+3.5%
Other revenues	888	4.2%	866	4.3%	+2.5%
Cost of sales	(5,598)	(26.6%)	(5,271)	(26.0%)	+6.2%
Gross profit	16,307	77.6%	15,899	78.3%	+2.6%
Research and development expenses	(3,219)	(15.3%)	(2,894)	(14.3%)	+11.2%
Selling and general expenses	(5,867)	(27.9%)	(5,967)	(29.4%)	-1.7%
Other current operating income	322	-	192	-	+67.7%
Other current operating expenses	(86)	-	(94)	-	-8.5%
Amortization of intangibles	(102)	-	(84)	-	+21.4%
Operating income – current	7,355	35.0%	7,052	34.7%	+4.3%
Restructuring costs	-	-	(30)	-	-
Impairment of PP&E and intangibles	(3)	-	(3)	-	-
Other operating income and expenses	520	-	44	-	-
Operating income	7,872	37.5%	7,063	34.8%	+11.5%
Financial expenses	(399)	-	(428)	-	-6.8%
Financial income	253	-	204	-	+24.0%
Income before tax and associates	7,726	36.8%	6,839	33.7%	+13.0%
Income tax expense	(2,282)	(10.9%)	(2,131)	(10.5%)	+7.1%
Effective tax rate	29.5%	-	31.2%	-	-
Share of profit/loss of associates	509	-	444	-	+14.6%
Consolidated net income	5,953	28.3%	5,152	25.4%	+15.5%
Minority interests	290	-	261	-	+11.1%
Net income after minority interests	5,663	26.9%	4,891	24.1%	+15.8%
Average number of shares outstanding (m)	1,346.1		1,335.8		
Earnings per share (in euros)	4.21		3.66		+15.0%

Appendix 4: 2006 third-quarter and 9-month reconciliations of consolidated income statement to adjusted consolidated income statement (unaudited)

2006 third-quarter reconciliation of consolidated income statement to adjusted consolidated income statement (unaudited)

The adjustments to the income statement reflect the elimination of material impacts of the application of purchase accounting to acquisitions, primarily the acquisition of Aventis, amounting to €637 million net of deferred taxes (with no cash impact for the Group) and restructuring charges (€12 million net of tax), i.e. a total impact of €649 million.

€ million	Q3 2006 Consolidated (unaudited)	Adjustments	Q3 2006 Adjusted consolidated (unaudited)
Net sales	6,901		6,901
Other revenues	241		241
Cost of sales	(1,843)	3 ^(a)	(1,840)
Gross profit	5,299	3	5,302
Research and development expenses	(1,075)		(1,075)
Selling and general expenses	(1,806)		(1,806)
Other current operating income	122		122
Other current operating expenses	(26)		(26)
Amortization of intangibles	(1,026)	990 ^(b)	(36)
Operating income – current	1,488	993	2,481
Restructuring costs	(17)	17 ^(c)	-
Impairment of PP&E and intangibles	2	(4) ^(d)	(2)
Other operating income and expenses	-		-
Operating income	1,473	1,006	2,479
Financial expenses	(119)		(119)
Financial income	66		66
Income before tax and associates	1,420	1,006	2,426
Income tax expense	(366)	(377) ^(e)	(743)
Share of profit/loss of associates	96	20 ^(f)	116
Consolidated net income	1,150	649	1,799
Minority interests	100		100
Net income after minority interests	1,050	649	1,699
Average number of shares outstanding (m)	1,348.0		1,348.0
Earnings per share (in euros)	0.78	0.48	1.26

The material impacts of the application of purchase accounting to acquisitions (primarily the acquisition of Aventis) and of restructuring charges on the 2006 third-quarter consolidated income statement are as follows:

- a) A charge of €3 million arising from the workdown of acquired inventories remeasured at fair value. This adjustment has no cash impact on the Group
- b) An amortization charge of €990 million against intangible assets. This adjustment has no cash impact on the Group.
- c) A pre-tax restructuring charge of €17 million.
- d) A reversal of impairment losses of €4 million. This adjustment has no cash impact on the Group.
- e) The tax impact primarily comprises:
 - 1. Deferred taxes of €372 million generated primarily by the amortization charge of €990 million taken against intangible assets, the reversal of impairment losses on intangibles of €4 million, and the €3 million charge arising from the workdown of acquired inventories remeasured at fair value. This adjustment has no cash impact on the Group.
 - 2. A tax saving of €5 million related to the €17 million of restructuring charges.
- f) In "Share of profit/loss from associates", a €20 million charge corresponding to amortization and impairment of intangibles (net of tax) and the workdown of acquired inventories. This adjustment has no cash impact on the Group.

2006 9-month reconciliation of consolidated income statement to adjusted consolidated income statement (unaudited):

The adjustments to the income statement reflect the elimination of material impacts of the application of purchase accounting to acquisitions, primarily the acquisition of Aventis, amounting to €2,167 million net of deferred taxes (with no cash impact for the Group) and restructuring charges (€65 million net of tax), i.e. a total impact of €2,232 million.

€ million	2006: 9 months Consolidated (unaudited)	Adjustments	2006: 9 months Adjusted consolidated (unaudited)
Net sales	21,017		21,017
Other revenues	888		888
Cost of sales	(5,611)	13 ^(a)	(5,598)
Gross profit	16,294	13	16,307
Research and development expenses	(3,219)		(3,219)
Selling and general expenses	(5,867)		(5,867)
Other current operating income	322		322
Other current operating expenses	(86)		(86)
Amortization of intangibles	(3,024)	2,922 ^(b)	(102)
Operating income – current	4,420	2,935	7,355
Restructuring costs	(98)	98 ^(c)	-
Impairment of PP&E and intangibles	(378)	375 ^(d)	(3)
Other operating income and expenses	520		520
Operating income	4,464	3,408	7,872
Financial expenses	(399)		(399)
Financial income	253		253
Income before tax and associates	4,318	3,408	7,726
Income tax expense	(1,018)	(1,264) ^(e)	(2,282)
Share of profit/loss of associates	421	88 ^(f)	509
Consolidated net income	3,721	2,232	5,953
Minority interests	290		290
Net income after minority interests	3,431	2,232	5,663
Average number of shares outstanding (m)	1,346.1		1,346.1
Earnings per share (in euros)	2.55	1.66	4.21

The material impacts of the application of purchase accounting to acquisitions (primarily the acquisition of Aventis) and of restructuring charges on the 2006 9-month consolidated income statement are as follows:

- a) A charge of €13 million arising from the workdown of acquired inventories remeasured at fair value. This adjustment has no cash impact on the Group.
- b) An amortization charge of €2,922 million against intangible assets. This adjustment has no cash impact on the Group.
- c) A pre-tax restructuring charge of €98 million.
- d) An impairment loss of €375 million, relating mainly to Ketek. This adjustment has no cash impact on the Group.
- e) The tax impact primarily comprises:
 - a. Deferred taxes of €1,231 million generated primarily by the amortization charge of €2,922 million taken against intangible assets, the impairment of intangibles of €375 million, and the €13 million charge arising from the workdown of acquired inventories remeasured at fair value. This adjustment has no cash impact on the Group.
 - b. A tax saving of €33 million related to the €98 million of restructuring charges.
- f) In "Share of profit/loss from associates", an €88 million charge corresponding to amortization and impairment of intangibles (net of tax) and the workdown of acquired inventories. This adjustment has no cash impact on the Group.

Appendix 5: Trends in selected adjusted income statement items (after tax)

€ million	Q1 2006	Q1 2005	Q2 2006	Q2 2005	Q3 2006	Q3 2005	2006 9 months	2005 9 months
Restructuring costs (Aventis pre-acquisition programs)	-	(9)	-	(10)	-	(2)	-	(21)
Net gains/(losses) on disposals	445	5	2	(1)	-	52	447	56
Provisions for investment portfolio, financial instruments and other items	21	1	(8)	(6)	-	54	13	49
TOTAL after tax	466	(3)	(6)	(17)	-	104	460	84

REMINDER**8.00 am CET - WEBCAST
& CONFERENCE CALL (English)**

The 3rd quarter 2006 sales and earnings will be reviewed today at **8.00 am** (Paris time) by Mr. Hanspeter Spek, Executive Vice-President, Pharmaceutical Operations and Mr. Jean-Claude Leroy, Executive Vice-President, CFO. The slides will be available on <http://www.sanofi-aventis.com>. This presentation will be followed by a Q&A session.

AUDIO REPLAY

Available online at <http://www.sanofi-aventis.com>

Exhibit W



ACOMPLIA®

Rimonabant

Leading the change in cardiovascular and metabolic (cardiometabolic) risk management

Crédit-Suisse Conference, November 9, 2006

Marc Cluzel

Senior Vice President, International Development,
Science and Medical Affairs

Pierre Chancel

Senior Vice President, Global Marketing





Forward Looking Statements

— This presentation contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words “expect,” “anticipates,” “believes,” “intends,” “estimates,” “plans” and similar expressions. Although sanofi-aventis’ management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under “Risk Factors” and “Cautionary Statement Regarding Forward-Looking Statements” in sanofi-aventis’ annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

sanofi aventis

Because health matters



Three big steps in managing the cardiometabolic risks....

1980s and beyond

Hypertension

\$48 billion

Outcome studies:
MRC-trials, HOT, ALL-
HAT, LIFE, HOPE,
VALUE, ASCOTT

Diuretics, Beta-
blockers, ACE-I,
CCBs, ARBs...

Novartis, Pfizer,
AstraZeneca, Merck &
Co, **sanofi-aventis**...

1990s and beyond

Statins

\$28 billion

Outcome studies:
4S, WOSCOPS, HPS,
CARE, REVERSAL

Lipitor®, Zocor®,
Pravachol®, Crestor®,
Lescol®...

Pfizer, Merck & Co,
BMS, AstraZeneca,
Novartis...

2000s and beyond

Diabetes

\$20 billion

Prevention studies:
DCCT, UKPDS

Actos®, Avandia®,
Lantus®, Humalog®,
Novorapid®, Byetta®...

Novo Nordisk, Takeda, GSK,
Eli Lilly, **sanofi-aventis** ...

Sales volume. IMS MAT March 2006

ACE-I – Angiotensin converting enzyme inhibitors

CCBs – Calcium channel blockers

ARBs – Angiotensin II receptor blockers

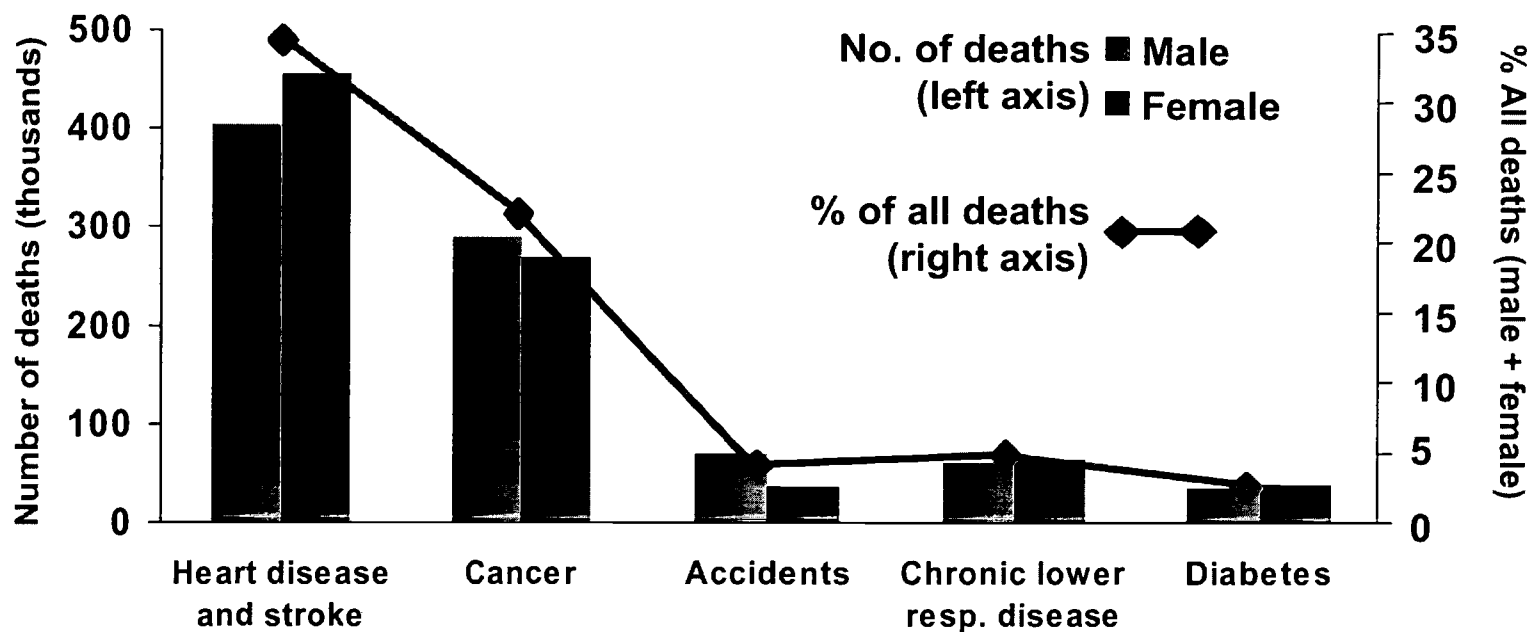
sanofi aventis

Because health matters



Despite therapeutic advances, cardiovascular disease remains the leading cause of death

Data for 2002 (US)



sanofi aventis

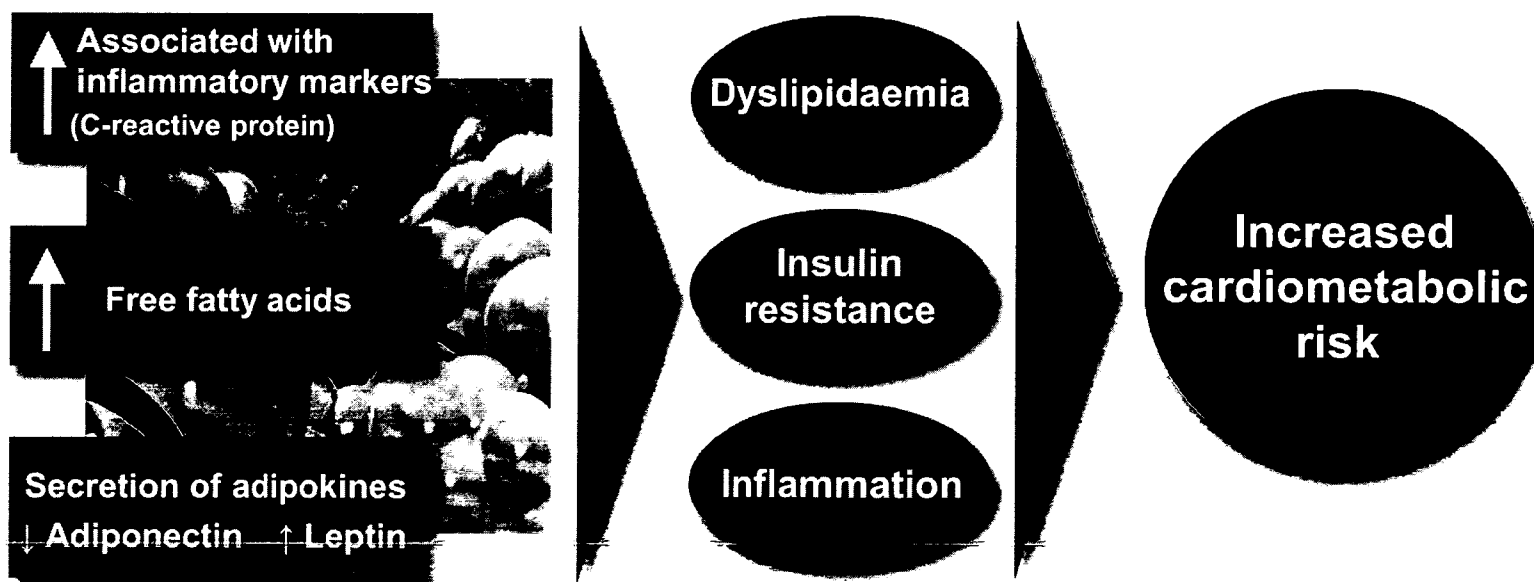
Because health matters

Source. National Center for Health Statistics, 2004



Intra-abdominal adiposity (IAA) is a major contributor to increased cardiometabolic risk

IAA = High Risk fat



Sources Kershaw EE, 2004, Lee YH, 2005,
Boden G, 2002, Després JP, 2001, Pouliot C, 2004

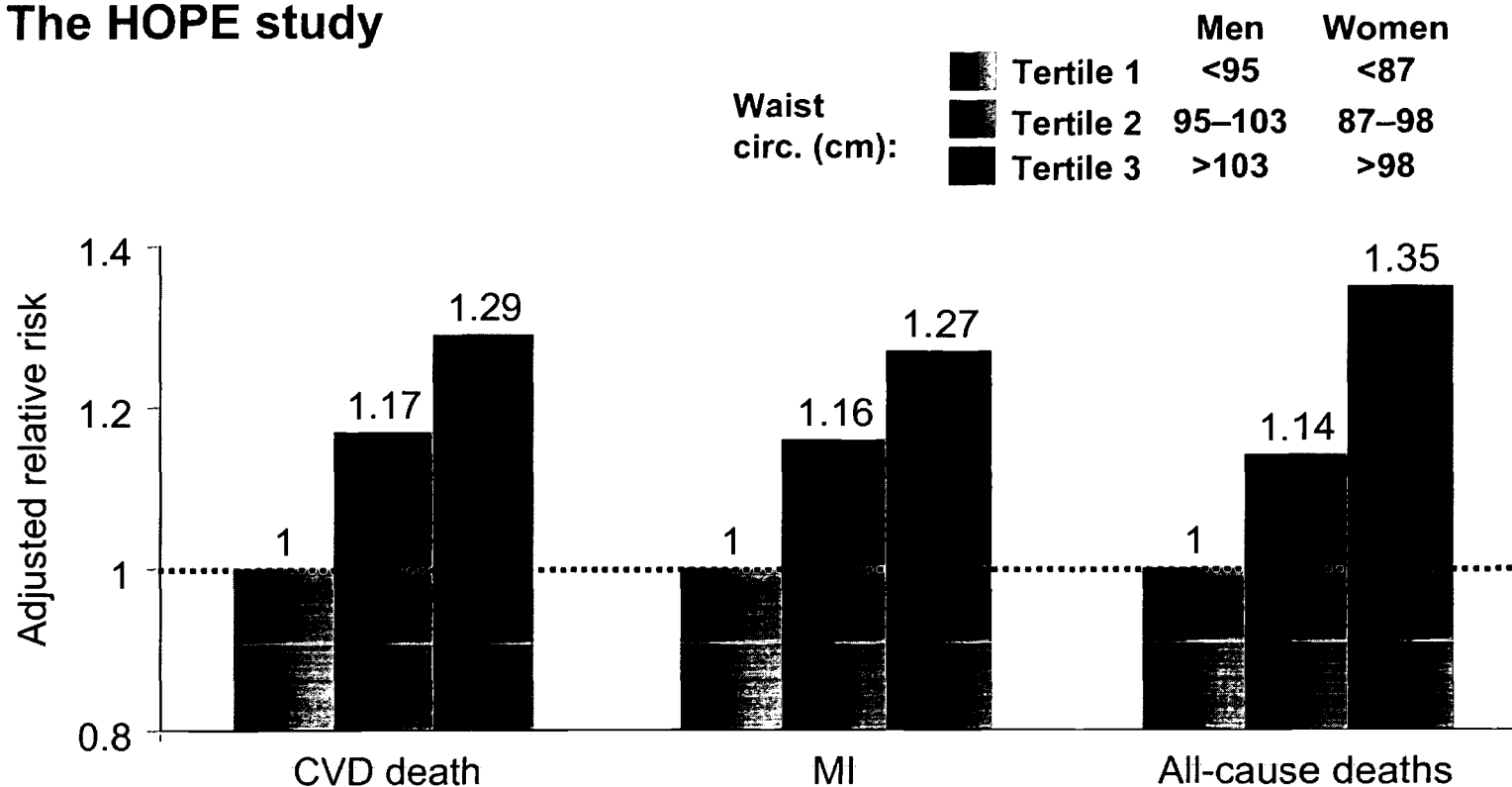
sanofi aventis

Because health matters



Risk of CV events increased with increasing waist circumference (abdominal obesity)

The HOPE study

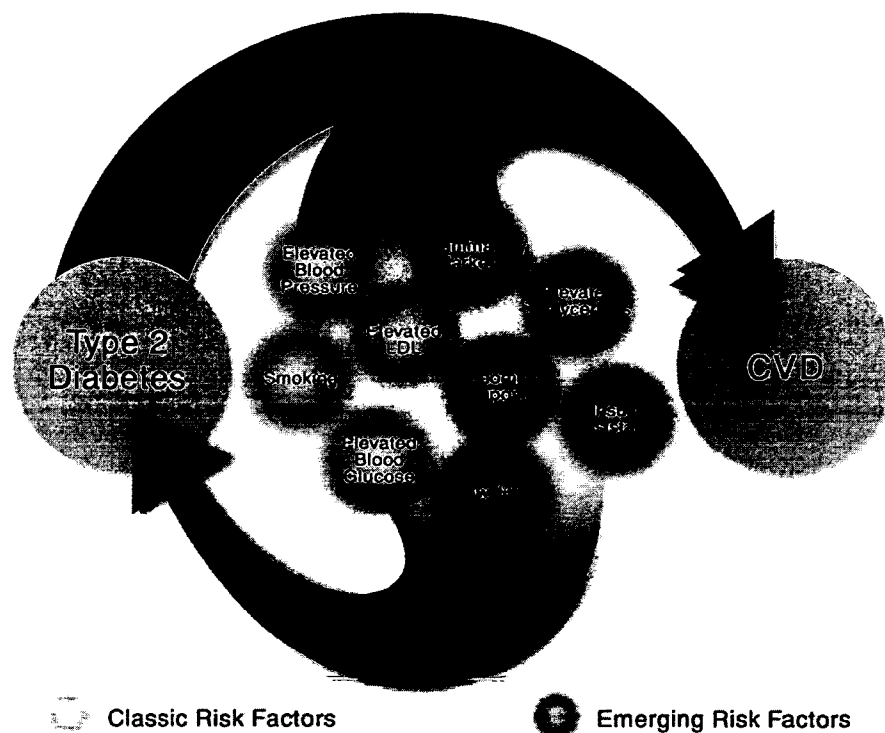


CV – Cardiovascular
 Adjusted for BMI, age, smoking, sex, CVD
 disease, DM, HDL-C, total-C
 Dagenais GR et al, 2005

sanofi aventis
 Because health matters



Need for a new approach to cardiometabolic risk management



Grouping of cardiometabolic risk factors poses a high risk






sanofi aventis

Because health matters



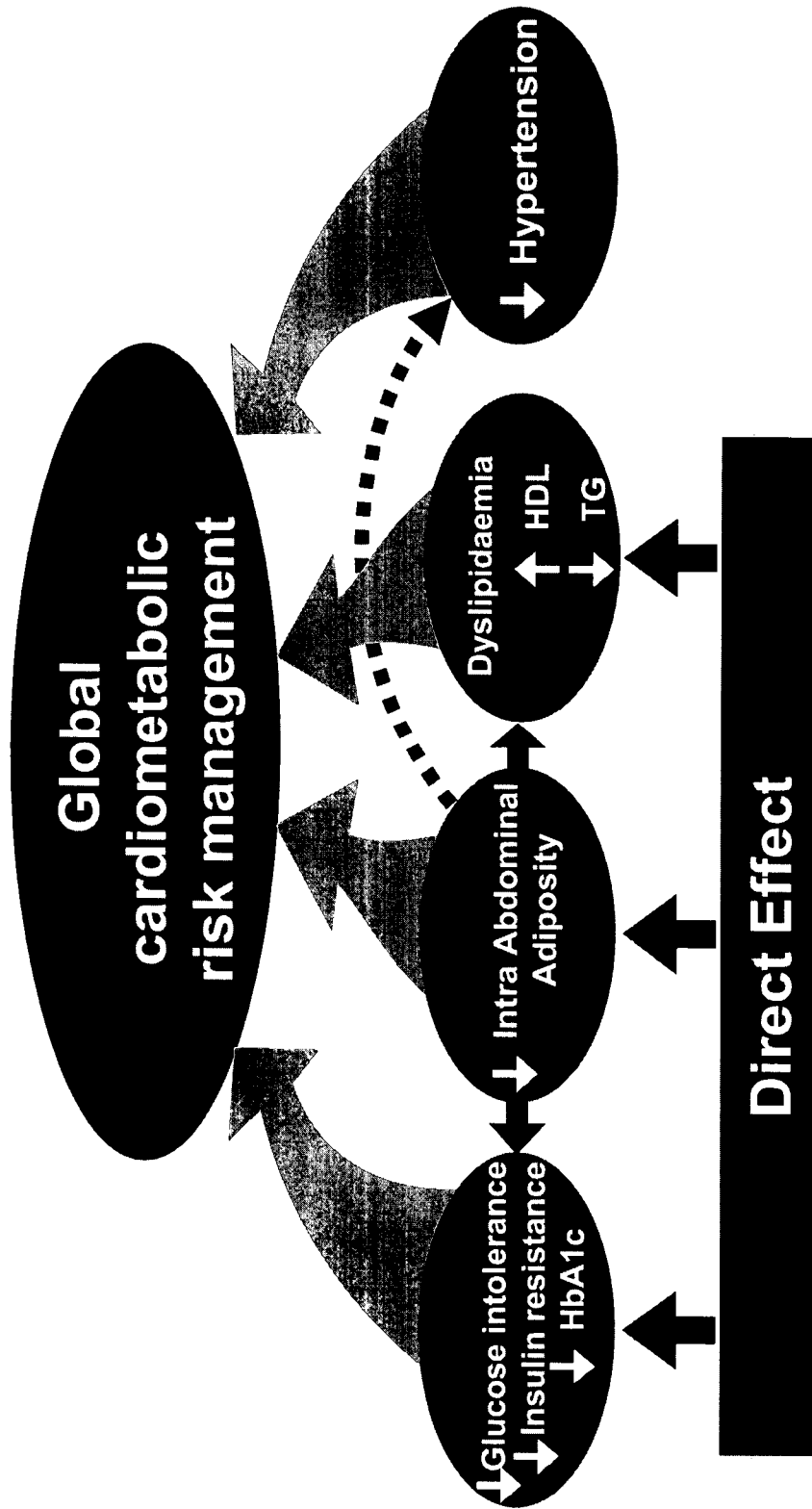
CB₁ receptor blockade helps addressing cardiometabolic risk factors

Sites of CB₁ receptors and potential effects of receptor blockade

	Site of action	Mechanism(s)	Addresses
	Hypothalamus /	↓ Food intake	Body weight
	Nucleus accumbens ^{1,2,3,4,5}		Intra-abdominal adiposity
	Adipose tissue / Intra-abdominal adiposity ^{1,2,3,4,5}	↑ Adiponectin	Dyslipidaemia
		↓ Lipogenesis	Insulin resistance
	Muscle ⁶	↑ Glucose uptake	Insulin resistance
	Liver ⁷	↓ Lipogenesis	Dyslipidaemia
			Insulin resistance
	GI tract ⁸	↑ Satiety signals	Body weight Intra-abdominal adiposity

1. Di Marzo V 2001; 2. Ravinet Trillou C, 2003;
 3. Cota D, 2003; 4. Pagotto U, 2005,
 5. Van Gaal L, 2005; 6. Liu Y 2005,
 7. Osei-Hyiaman D 2005; 8. Massa F, 2005

Acomplia® – The RIO program **Redefining management of cardiometabolic risk**



sanofi aventis
Because health matters



Acomplia®: CHMP recommendation for approval in the European Union

———— Indication reflecting all the results of the RIO program:

“As an adjunct to diet and exercise for the treatment of obese patients ($BMI \geq 30\text{kg/m}^2$), or overweight patients ($BMI > 27\text{ kg/m}^2$) with associated risk factors, such as type 2 diabetes or dyslipidemia (See section 5.1)”

———— **Section 5.1 - Summary of Product Characteristics**

Statements in this section stipulate that half of the observed improvements in HbA1c, HDL cholesterol and triglycerides were beyond that expected from weight loss alone

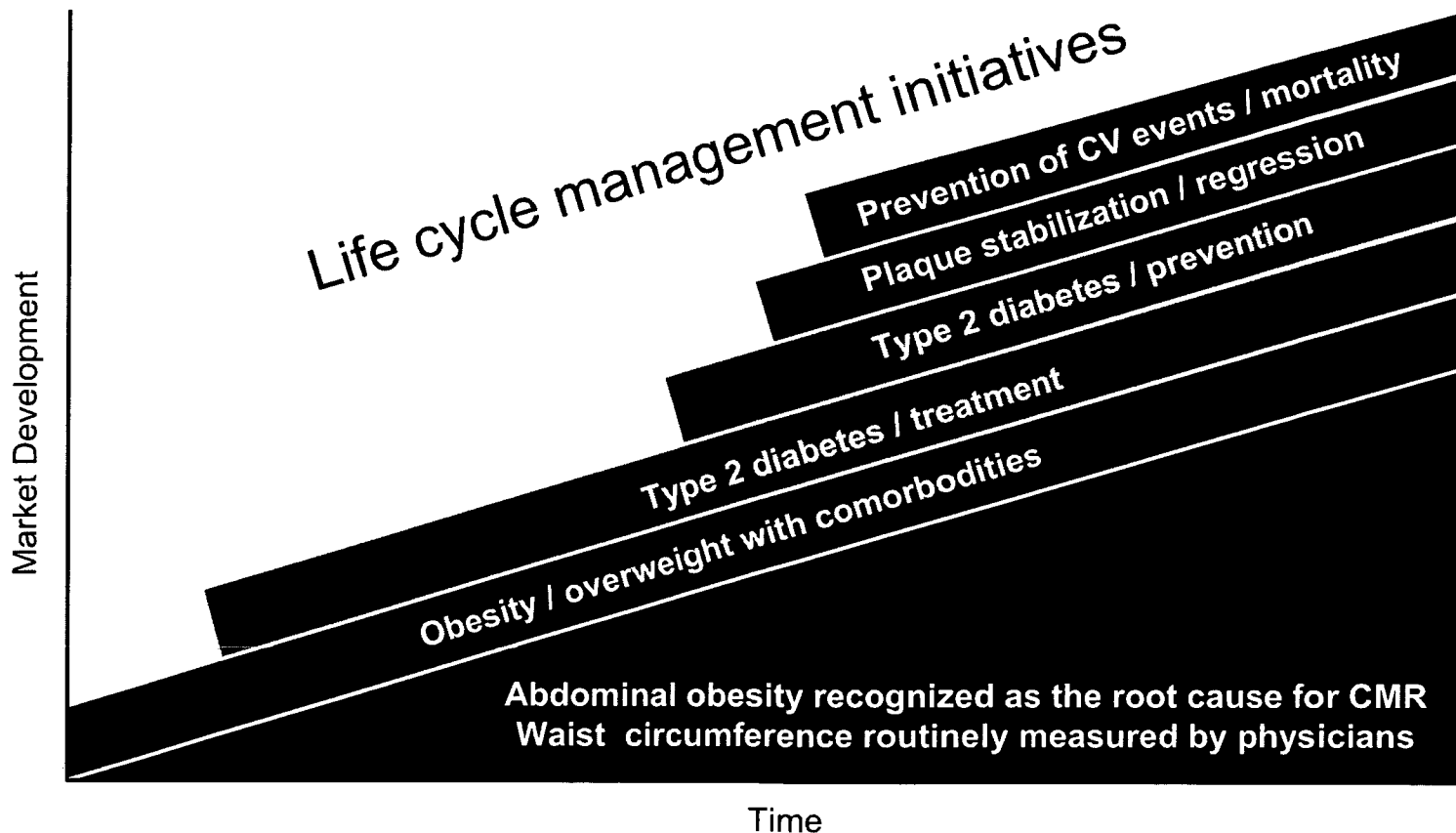
———— **No major contra indications**

sanofi aventis

Because health matters



Acomplia®: Exploring its potential across the risk continuum







sanofi aventis

Because health matters



Clinical evidence derives from the RIO program: More than 6,600 patients involved





Study	Population	N=6627	Design	Publication
 RIO NORTH AMERICA	Obese or overweight with/without comorbidities (excluding diabetes)	3040	1+1 year Re- randomized	Journal of the American Medical Association
 RIO EUROPE	Obese or overweight with/without comorbidities (excluding diabetes)	1507	2 years	The Lancet
 RIO LIPIDS	Obese or overweight with untreated dyslipidaemia (excluding diabetes)	1033	1 year	New England Journal of Medecine
 RIO DIABETES	Obese or overweight with type 2 diabetes (suboptimally controlled by metformin or sulphonylurea)	1045	1 year	The Lancet

Pi-Sunyer FX et al, 2006; Després JP et al, 2005,
Van Gaal L et al, 2005, Scheen A et al, unpublished

sanofi aventis
Because health matters



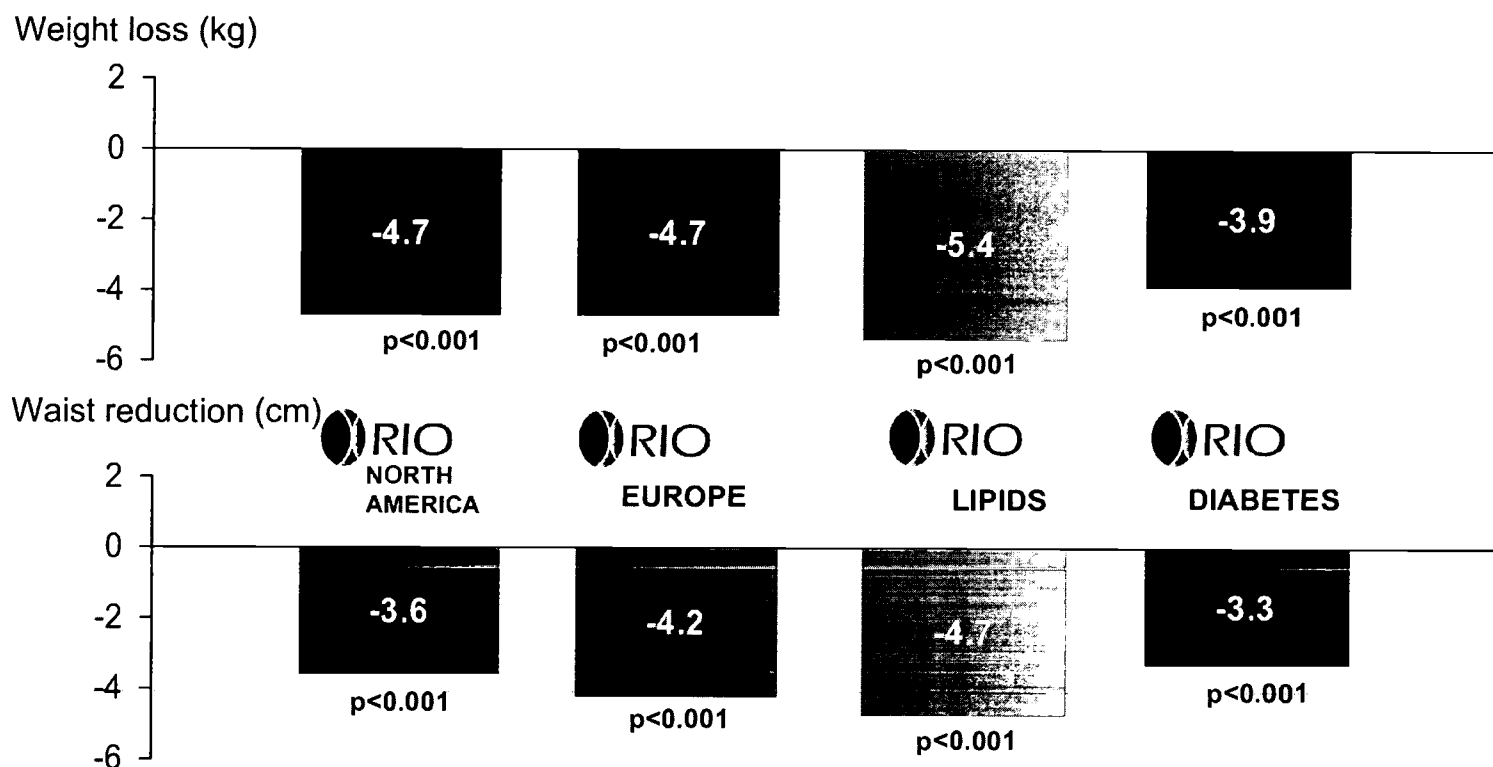
Patients in RIO trials had an increased risk of CV complications and of becoming diabetic

	 RIO NORTH AMERICA (N=3040)	 RIO EUROPE (N=1507)	 RIO LIPIDS (N=1033)	 RIO DIABETES (N=1045)
Abdominal obesity Men (>102 cm)	89.6%	93.5%	78.6%	81.3%
Women (>88 cm)	86.9%	94.7%	91.2%	96.6%
Dyslipidaemia	62.6%	60.7%	100 %	55.6%
TG ≥ 1.69 mmol/L	33.4%	27.4%	57.4%	53.0%
HDL-C < 1.03mmol/L (men)	50.3%	50.0%	62.6%	45.1%
HDL-C < 1.3 mmol/L (women)	52.8%	54.3%	70.7%	58.3%
LDLC ≥ 3.36 mmol/L	34.9%	40.6%	58.2%	32.7%
Drug treatment if dyslipidaemic	15.1%	13.7%	0%	64.9%
Diabetes	0	0	0	100%
Pre-diabetes				
Fasting glucose ≥ 5.55 mmol/L	20.7%	29.3%	28.7 %	
2h post glucose load ≥ 7.77 mmol/L		15.4 %	22.6 %	
Hypertension	30.4%	40.9%	27.2%	61.2%
Drug treatment if hypertensive	68.1%	55.1%	68.7%	93.0%
Metabolic syndrome (ATP III)	34.7%	41.4%	54.0%	79.3%



Consistent improvement in body weight and waist circumference across RIO studies

Acomplia® 20 mg – Placebo-subtracted change⁽¹⁾ for weight and waist



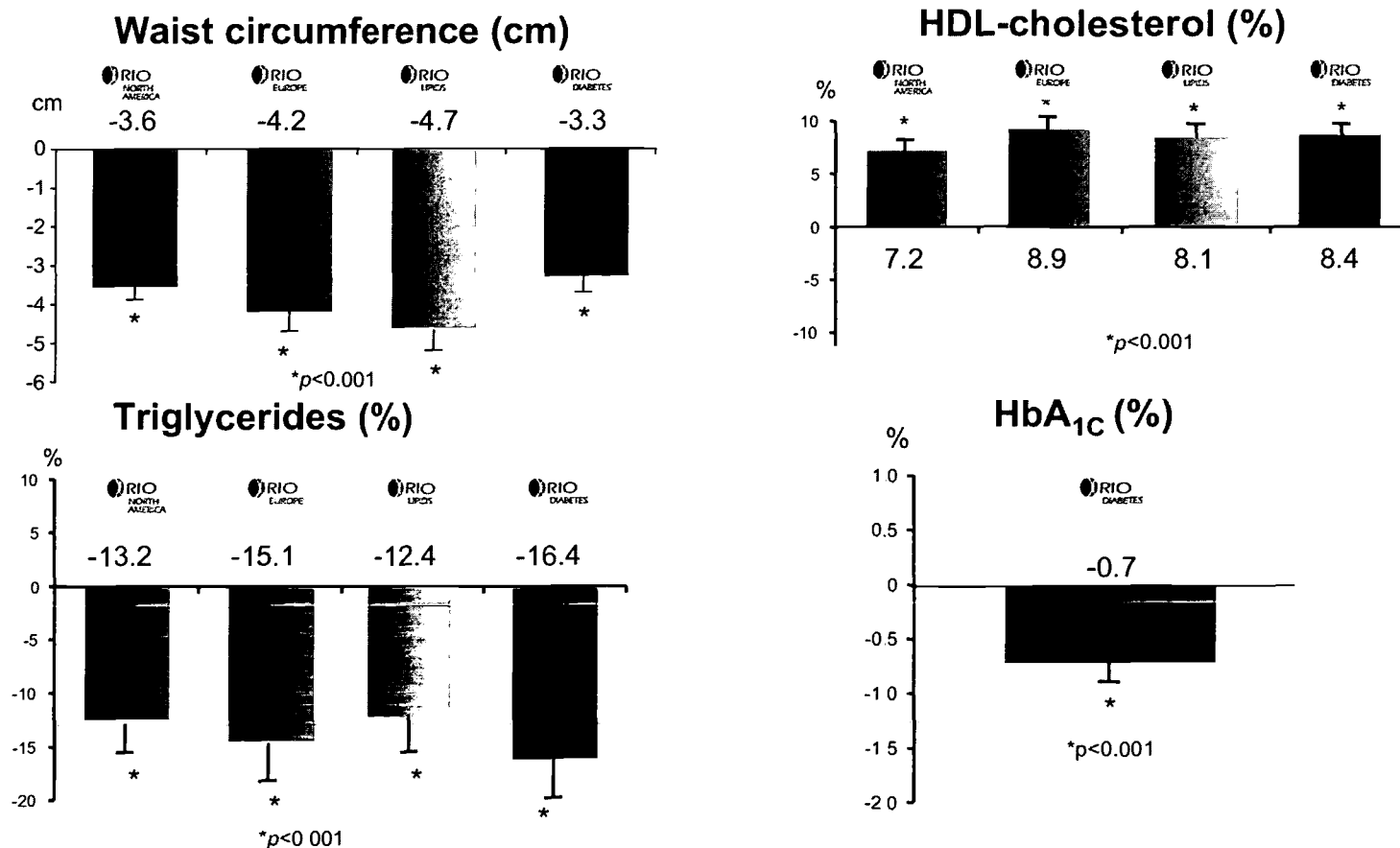
sanofi aventis

Because health matters



Acomplia[®] consistently improved cardiometabolic risk factors in RIO trials

Acomplia[®] 20 mg – Placebo-subtracted change⁽¹⁾ for multiple CMR factors



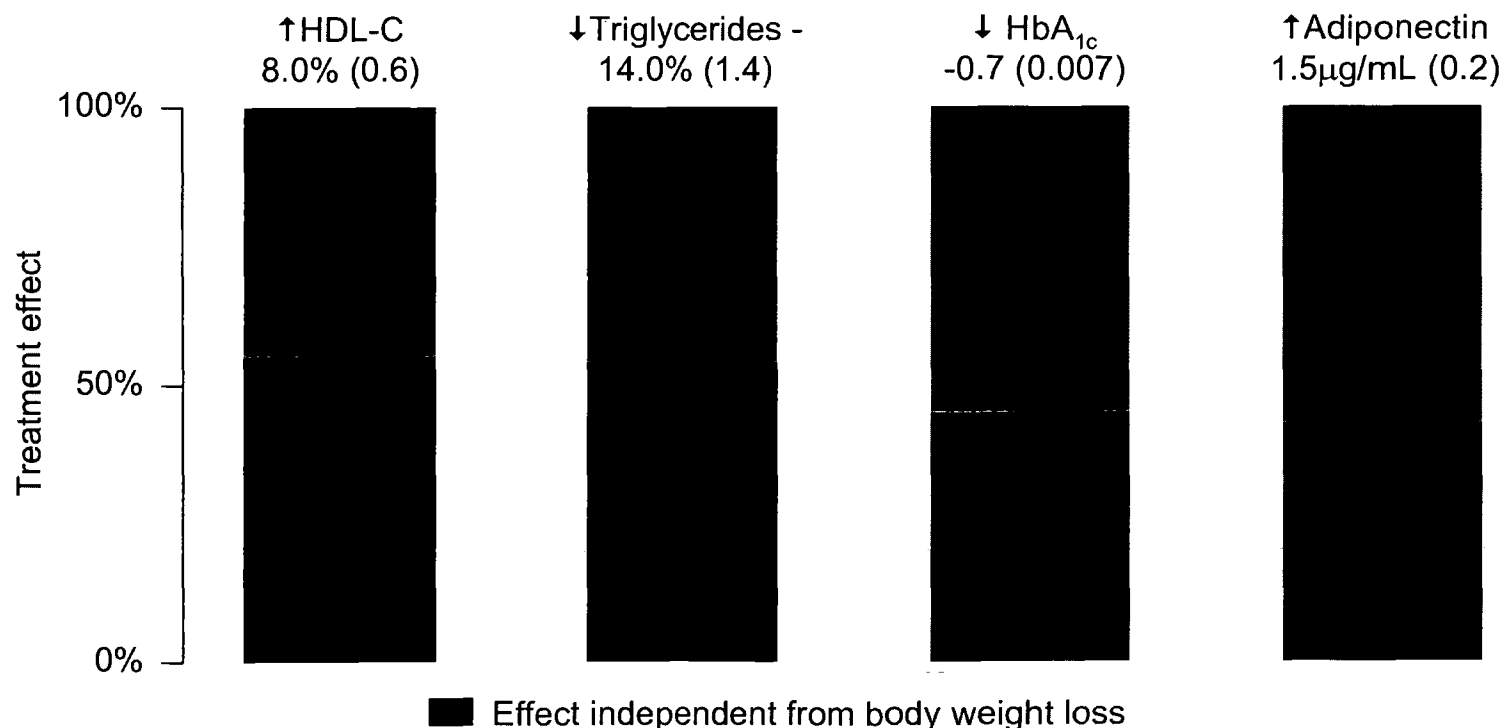
(1) Mean (+ SEM) intent to treat population, LOCF
Pi-Sunyer FX et al, 2006, Després JP et al, 2005,
Van Gaal L et al, 2005; Scheen A et al, unpublished

sanofi aventis
Because health matters



Effects of Acomplia® on CMR factors due to a direct CB₁ blockade in peripheral tissues

~50% of improvement⁽¹⁾ in metabolic parameters due to direct effect









(1) Mean (SEM) – Data on file
 HDL-C and TG data from the 4 RIO studies
 HbA_{1c} from RIO Diabetes
 Adiponectin from RIO Lipids
 CMR – Cardiometabolic risk

sanofi aventis
 Because health matters



No increased AE reporting and discontinuation rate during 2nd year of treatment

	   		 	
	Year 1		Year 2	
	Placebo (n=1602)	Rimonabant 20 mg (n=2503)	Placebo (n=466)	Rimonabant 20 mg (n=688)
Subjects with any adverse event	81.8 %	86.0 %	77.0 %	76.7 %
Subjects with any serious adverse event	4.2 %	5.9 %	5.4 %	4.5 %
Subjects discontinued due to adverse event	7.2 %	13.8 %	4.7 %	4.7 %

AEs – Adverse events
Data on file

sanofi aventis
Because health matters



AEs most frequently reported involved gastrointestinal tract, dizziness and anxiety

AEs \geq 5% in year 1 – Preferred term (%)	Placebo n=1602	Rimonabant 20 mg n=2503
Nasopharyngitis	17.5	16.3
URTI	11.4	12.4
Nausea	4.9	11.9
Headache	11.8	9.4
Influenza	8.6	8.9
Arthralgia	8.2	8.1
Dizziness	4.9	7.5
Back pain	7.6	7.0
Sinusitis	8.0	6.5
Diarrhoea	4.8	6.3
Asthenia/fatigue	5.0	6.0
Anxiety	2.4	5.6
Insomnia	3.2	5.4

Individual TEAEs reported in \geq 5% in any treatment group

AEs – Adverse events
 URTI – Upper respiratory tract infection
 TEAE – Treatment emergent adverse events
 Data on file

sanofi aventis
 Because health matters



Acomplia® clinical safety: Summary

- _____ **Most frequent reported AEs were gastrointestinal and CNS in nature**
- _____ **AEs usually occurred during the 1st months and were generally of mild to moderate intensity**
- _____ **Safety profile in year 2 was generally not different from that of placebo or year 1**
- _____ **Increased incidence of depression-related events and anxiety on Acomplia® – Overall incidence remained relatively low and most AEs were mild to moderate intensity and non-serious**
- _____ **Long term exposure did not identify new or increased risks**
- _____ **No adverse changes in laboratory tests, ECG or vital signs**

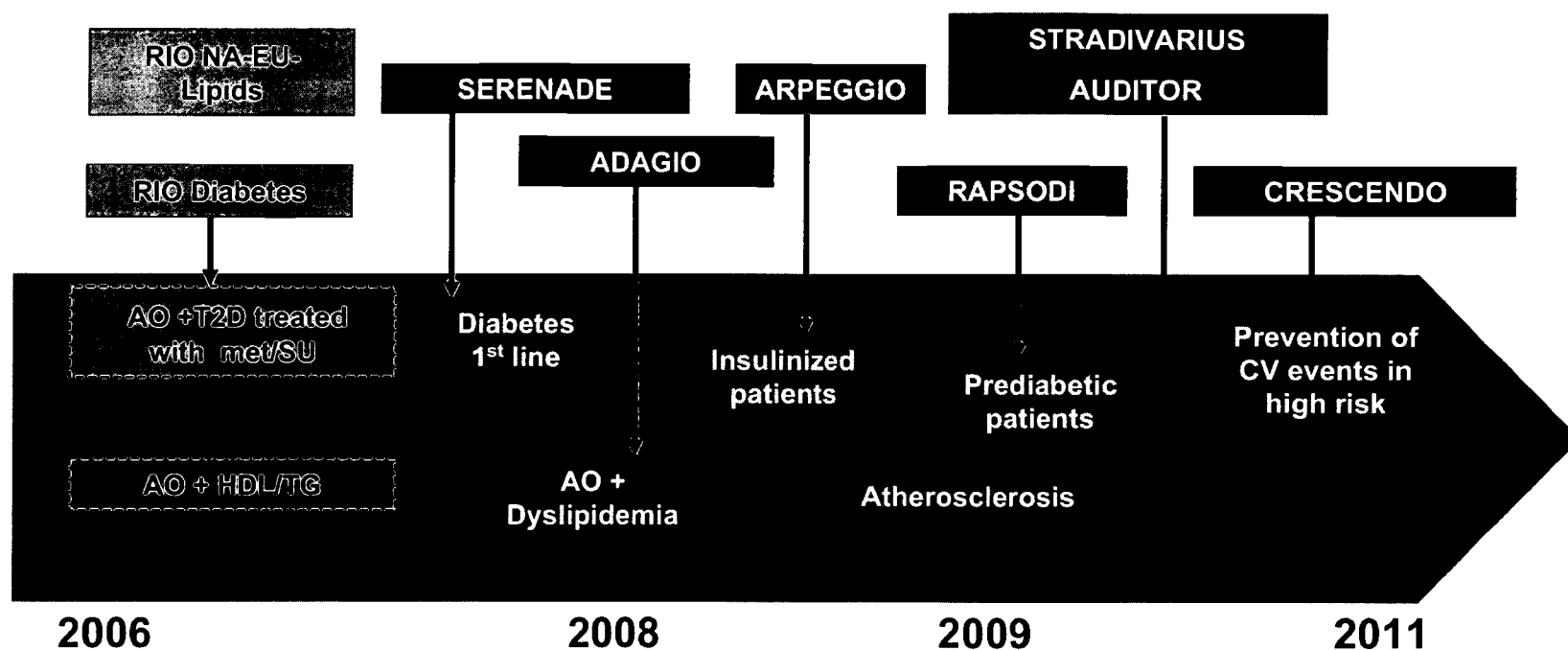
AEs – Adverse events
Data on file

CNS – Central nervous system

sanofi aventis
Because health matters



Acomplia®: From high global cardiometabolic risk to cardiovascular disease prevention



AO – Abdominal obesity
T2D – Type 2 diabetes
SU – Sulfonylurea

CV – Cardiovascular
MET – Metformine

sanofi aventis
Because health matters



Acomplia[®] phase IIIb trials in type 2 diabetes: Impact on disease control and progression

Study name	Key objectives / Type of patients	Treatment duration	# of patients	Study start
SERENADE	Improvement of glycemic control / Treatment naïve type 2 diabetes patients	6 months	281	Q1 2005
ARPEGGIO	Improvement of glycemic control (HbA _{1c}) in type 2 diabetes patients poorly controlled with insulin	12 months	368	Q1 2006
RAPSODI	Prevention of type 2 diabetes / Pre-diabetes patients	24 months	2,100	Q2 2006

sanofi aventis

Because health matters



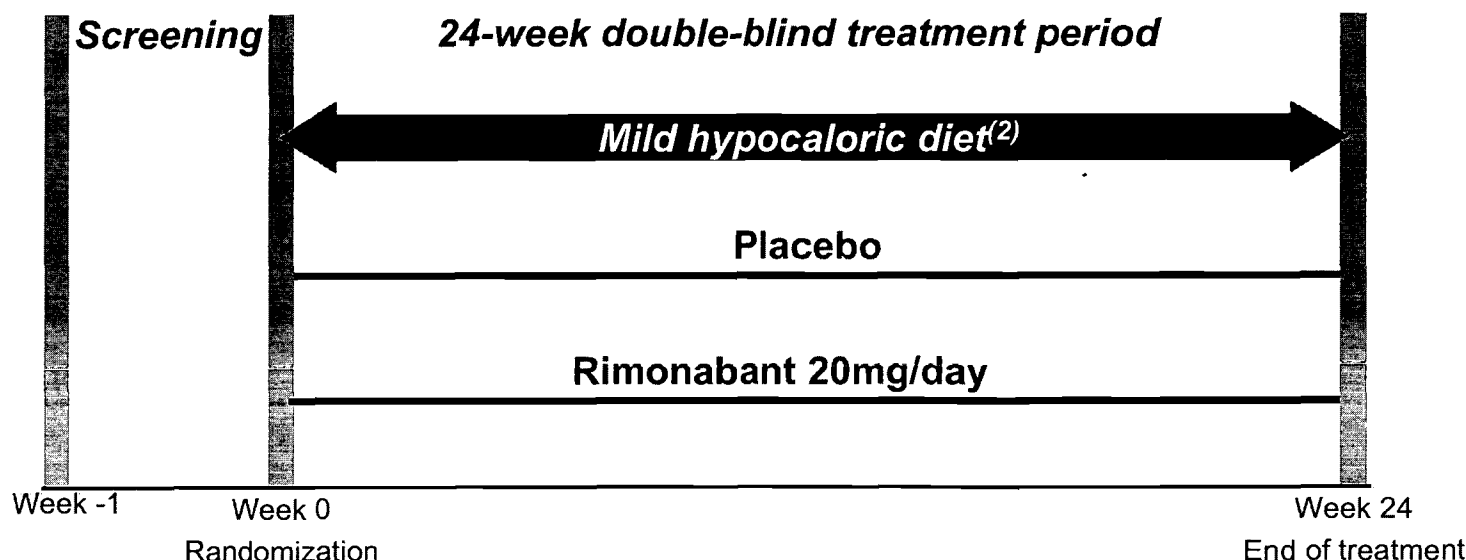
Acomplia[®]: Serenade study results to be presented at 19th World Diabetes Congress¹

— Patient population: Treatment naïve type 2 diabetes patients

● (obesity not an inclusion criteria)

— Primary objective: HbA_{1c} change from baseline over 6 months

— Number of patients: 281 randomized (1:1 randomization)



Serenade – Study Evaluating Rimonabant Efficacy in drug-Naive Diabetic patients

(1) International Diabetes Foundation congress, Capetown, 3-7 December 2006

(2) Basal energy expenditure reduced by 600 Kcal/day, as per American Diabetes Association Recommendations

sanofi aventis
Because health matters



Acomplia[®] phase IIIb trials in CV disease: Impact on atherosclerosis and CV outcomes

Study name	Key objectives / Type of patients	Treatment duration	# of patients	Study start
CRESCENDO	Reduction in the risk of heart attack (MI), stroke or death from an MI or stroke / Patients with abdominal obesity and coronary heart disease or major CV risk factors	50 months	17,000	Q4 2005
AUDITOR	Progression of atheroma plaque in carotid artery as assessed by IMT / Patients with abdominal obesity and associated CV risk factors	24 months	661	Q3 2005
STRADIVARIUS	Progression of atheroma plaque in coronary arteries as assessed by IVUS	18 months	839	Q1 2005
ADAGIO-Lipids	Efficacy on HDL cholesterol and triglycerides / Abdominally obese patients with atherogenic dyslipidemia	12 months	803	Q2 2005

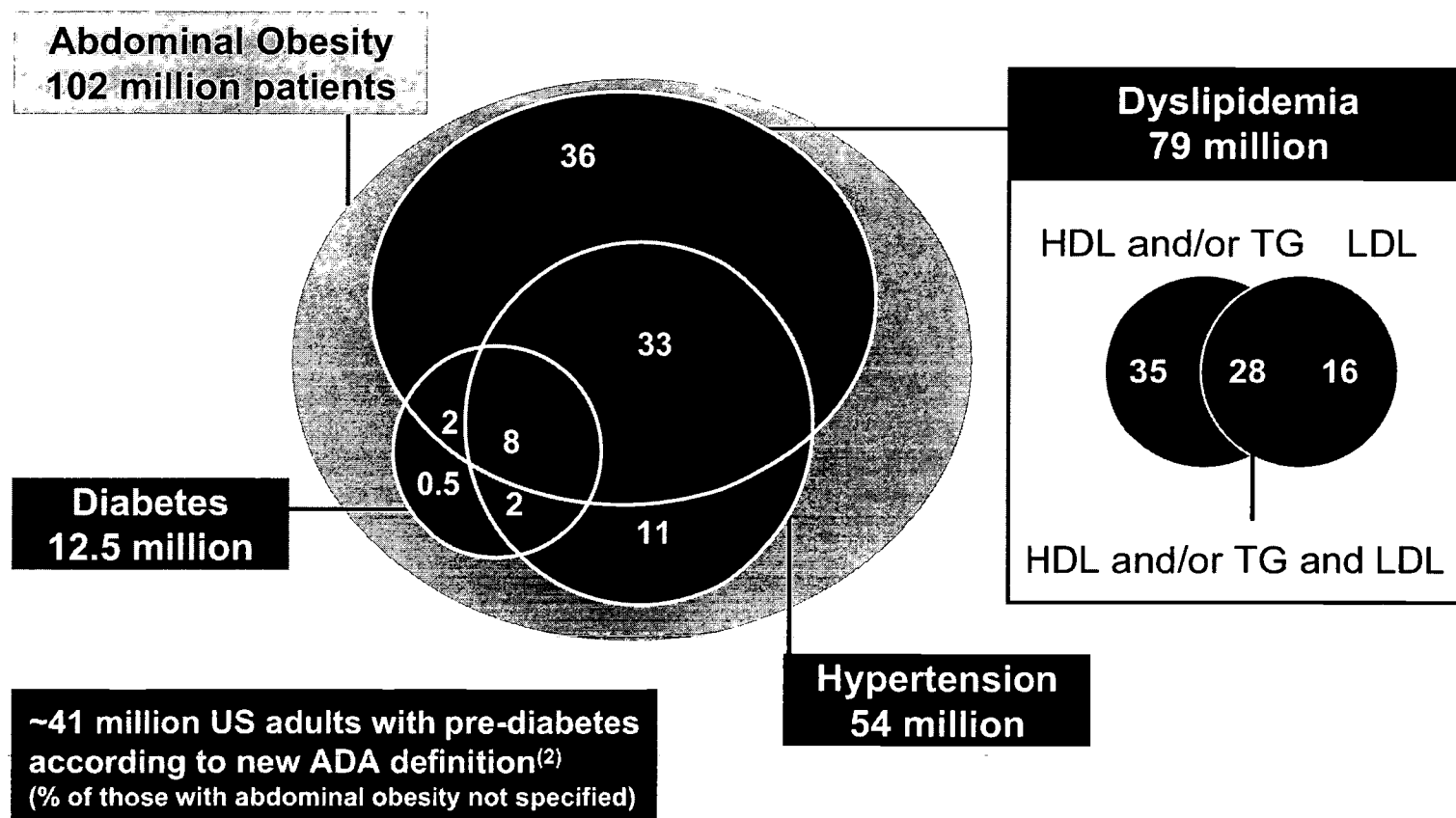
CV – Cardiovascular
IMT – Intima media thickness
IVUS – Intravascular ultrasound

sanofi aventis

Because health matters



A huge number of patients at cardiometabolic risk – U.S. (1999-2002)⁽¹⁾



(1) Data from the National Health and Nutrition Examination Survey (1999-2002)

(2) Impaired fasting glucose. 100mg/dl vs 110 mg previously, as per American Diabetes Association, Diabetes Care, 2003

sanofi aventis

Because health matters



To successfully launch Acomplia®

- _____ **Positioning in the right patient profile is a key element**
- _____ **Physicians' first experiences with first patients are important**
- _____ **Treatment continuation is as important as initiating new patients**

sanofi aventis

Because health matters



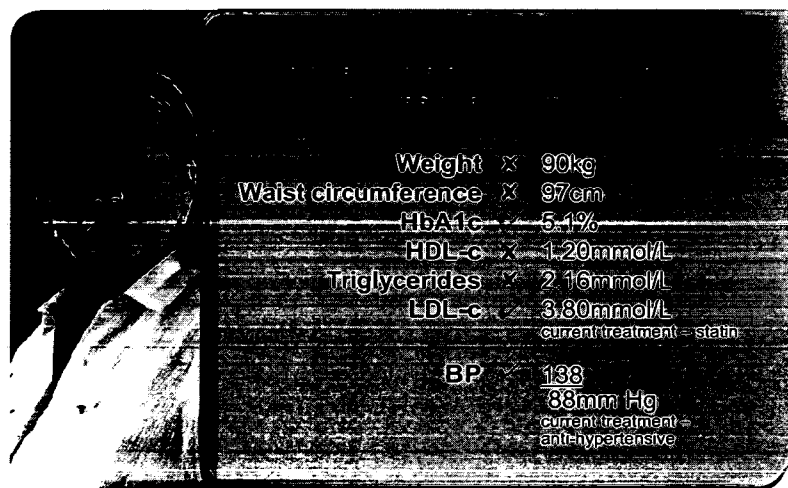
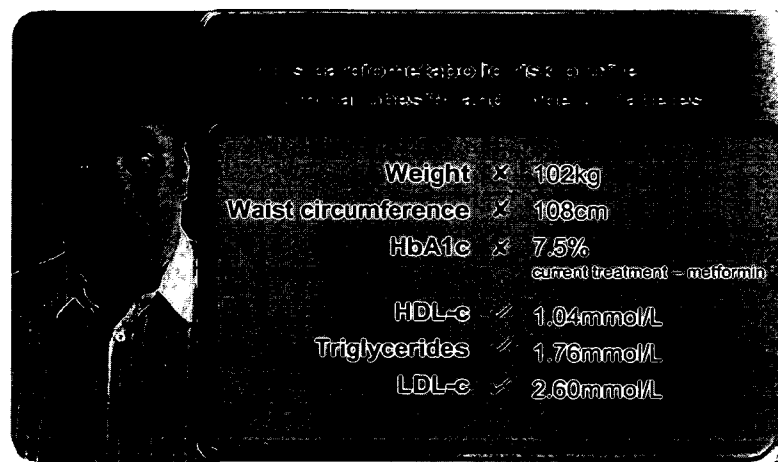
Optimal use in obese/overweight patients with comorbidities

Optimal use

- Patients most likely to benefit from Acomplia® are those with multiple CMR factors that are improved by the drug

- 【 Abdominal obesity* and type 2 diabetes
- 【 Abdominal obesity* and dyslipidaemia (low HDL and/or high TG)

*Patients having BMI >27 kg/m² and large waist circumference



sanofi aventis

Because health matters

CMR – Cardiometabolic risk
BMI – Body mass index TG – Triglycerides



The « responsible » promotion to drive appropriate use in the right patients

Discourage suboptimal use, i.e. in

- Patients with no comorbidities
- Patients seeking weight loss for cosmetic reasons
- Patients not ready to embrace lifestyle changes
- Patients not ready to embrace long-term treatment

Encourage respect of precautions for use such as

- Do not initiate treatment in patients with uncontrolled psychiatric illness
- Not recommended in patients treated with an antidepressant



BMI – Body mass index

sanofi aventis

Because health matters

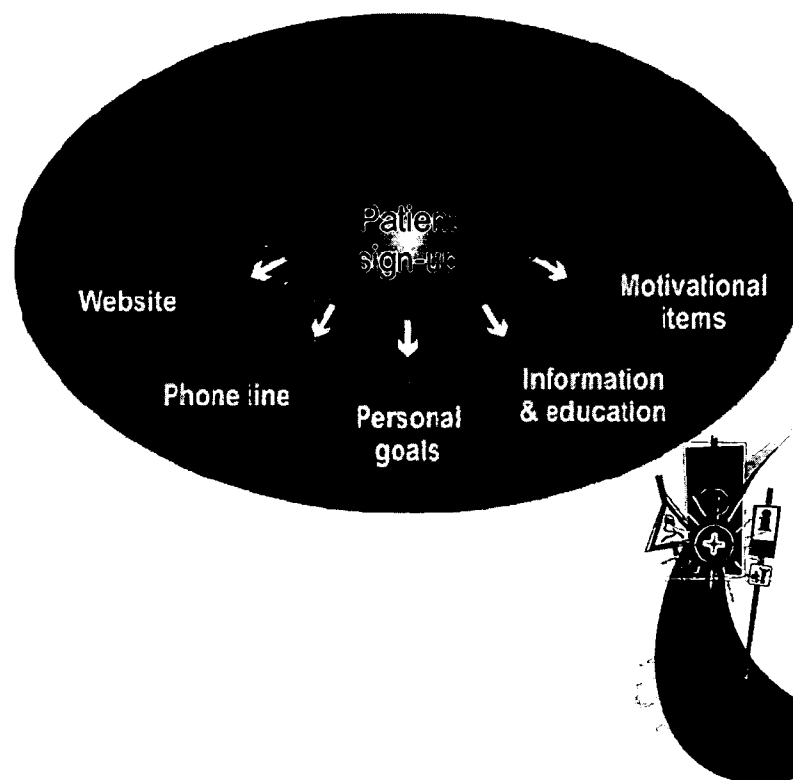


Patient support program: Leverage the right patient for Acomplia®

Comprehensive support program for patients on Acomplia® - Objectives

- Complement healthcare providers' advices
- Receive information, advices and motivational items
- Set personal goals and monitor progress
- Help compliance

« It's what you gain » program



sanofi aventis

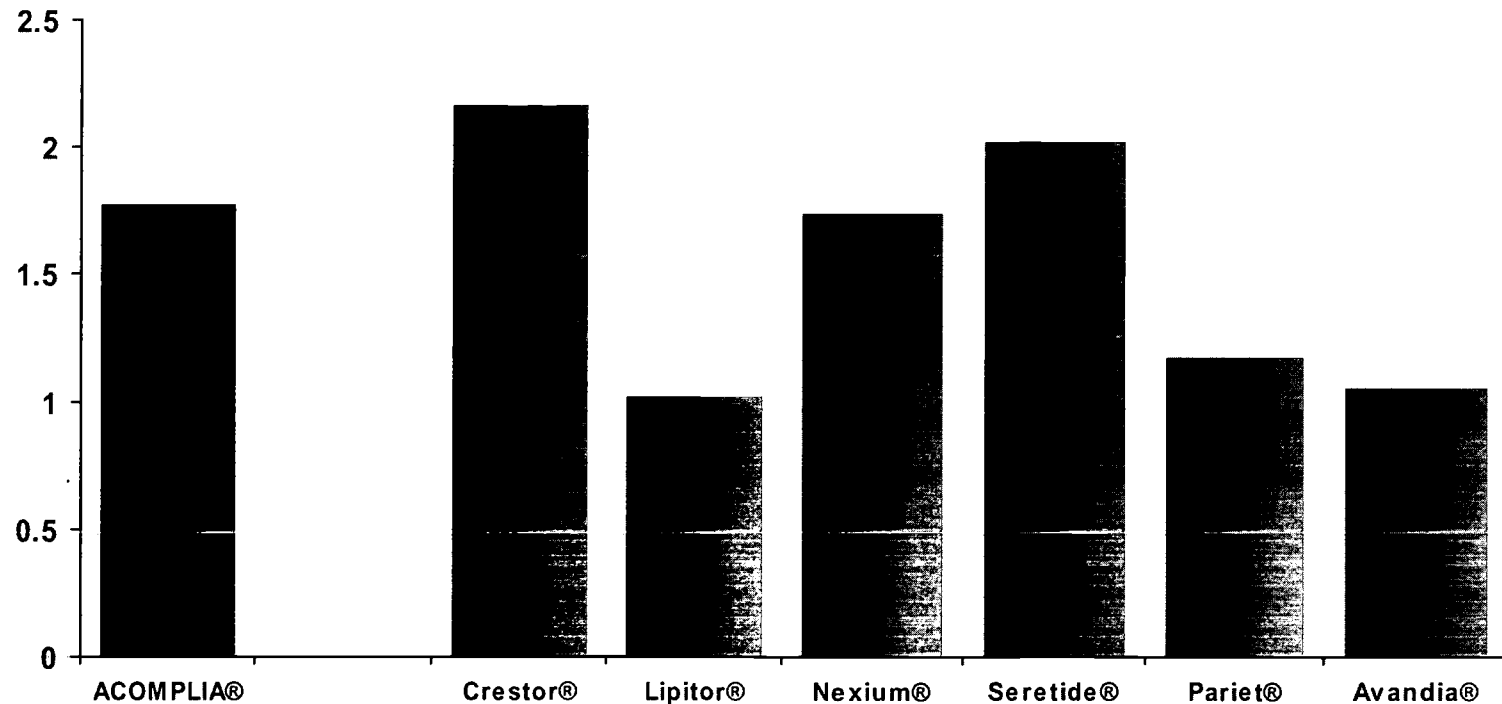
Because health matters



Acomplia®: After 3 months, launch is comparable to TOP 6 UK launches

Demand sales three months after launch⁽¹⁾

Million Euros



sanofi aventis

Because health matters

(1) IMS BPI + HPAI

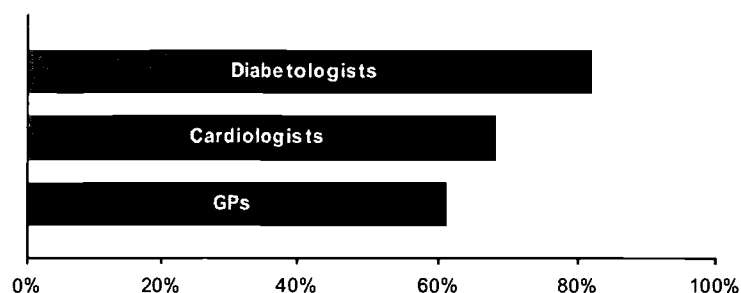


Acomplia®: High focus from UK physicians on the right patients

High interest from UK physicians

- Target doctors indicating high likelihood to start / increase prescribing

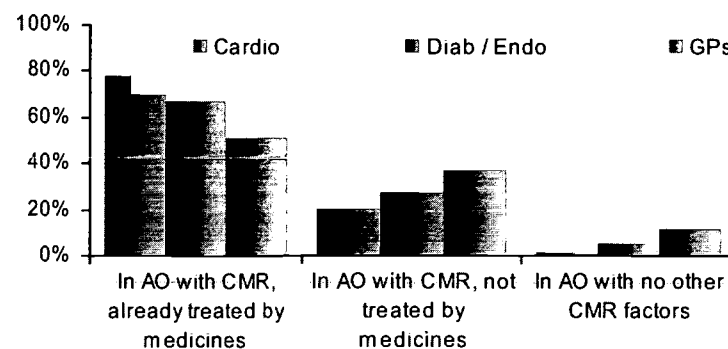
Physicians likely to start / increase Rx⁽¹⁾



Being used in the right patients

- Vast majority of patients are overweight / obese with cardiometabolic risk factors

Physicians likely to initiate Acomplia® in obese patients with CMR⁽¹⁾

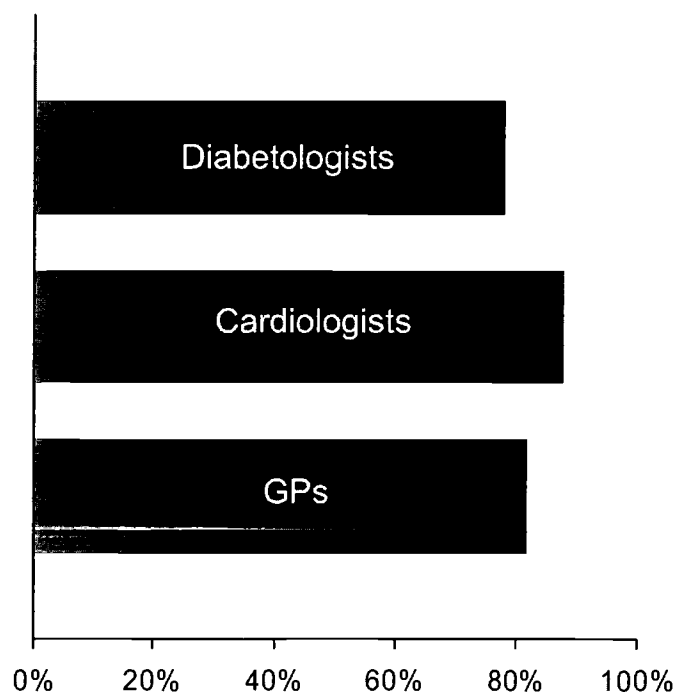


(1) Source. Silver Fern research Acomplia DFU Primary and Secondary Care – Sept'06



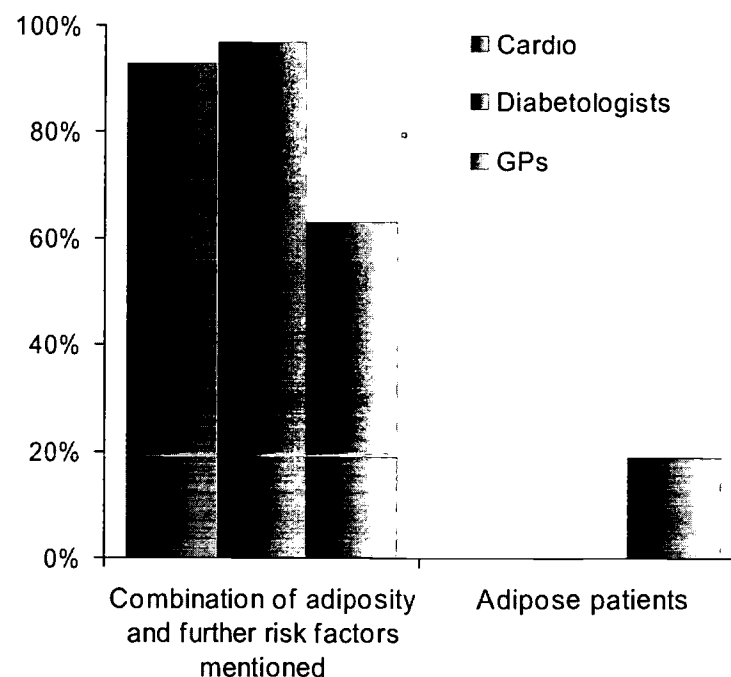
Acomplia®: German physicians expressing high intention to use

Physicians likely to prescribe Acomplia® (1)



Physicians likely to initiate Acomplia® in obese patients with CMR(1)

Potential patients for the treatment with Acomplia®



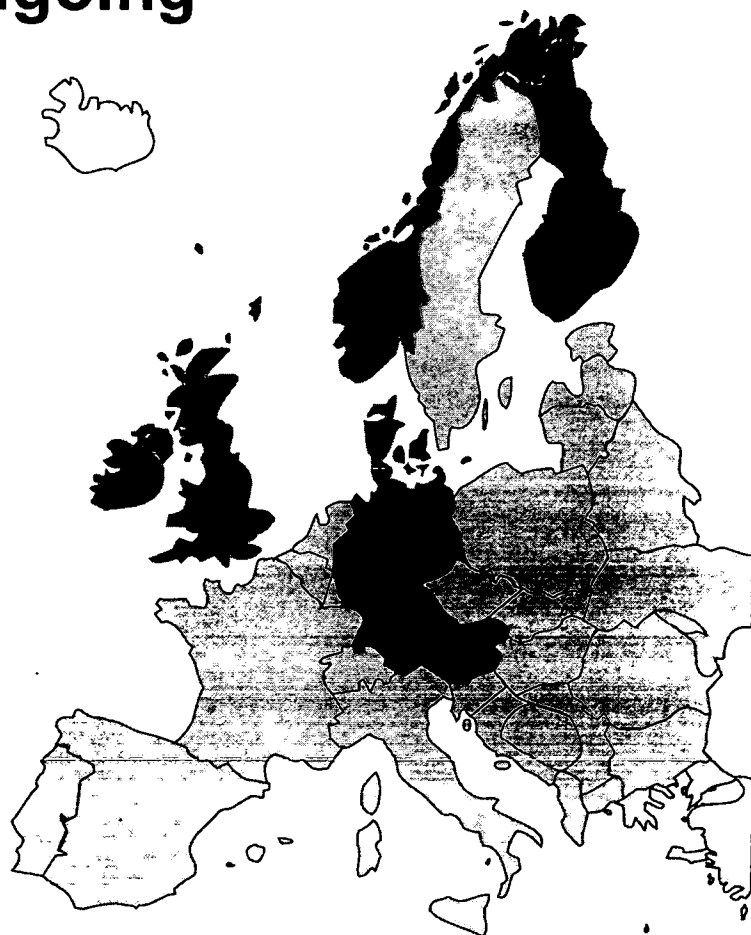
(1) Source: Concentra Market Research
Acomplia DFU Primary and Secondary Care

sanofi aventis

Because health matters



Acomplia® launches in European countries ongoing



- **Already launched**
 - ✓ UK (June)
 - ✓ Denmark (August)
 - ✓ Germany, Ireland, Finland, Norway (September)
 - ✓ Austria (October)
- **Launches planned in 2007 (most countries) and in 2008**

sanofi aventis

Because health matters



Conclusion

————— **Acomplia[®], the first selective CB₁ blocker**

————— **Acomplia[®] treatment results in improvements in multiple CMR factors**

- **Half of the improvement independent from body weight loss**

————— **Early feedback from first EU launches positive**

————— **Launch efforts focusing on patients**

- **Overweight / obese patients with comorbidities**

————— **Ongoing phase IIIb studies to expand scientific knowledge and potentially give access to new patient populations**

sanofi aventis

Because health matters

Exhibit X

Copyright 2006 Voxant, Inc.
All Rights Reserved.
Copyright 2006 CCBN, Inc.
All Rights Reserved.
FD (Fair Disclosure) Wire

December 5, 2006 Tuesday

TRANSCRIPT: 120506aw.793

LENGTH: 8726 words

HEADLINE: Sanofi-Aventis announces Acomplia® (rimonabant) - Serenade study clinical data - Conference Call - Final

BODY:

OPERATOR: Good day ladies and gentlemen and welcome to today's Sanofi-Aventis Serenade study clinical data conference call. For your information, this call is being recorded. At this time, I would like to turn the call over to your host today, Mr. Sanjay Gupta, Head of Investor Relations of Sanofi-Aventis. Please go ahead, sir.

SANJAY GUPTA, HIR, SANOFI-AVENTIS: Thank you [Anita]. Good afternoon, everybody. Good morning to those in the States. As you know, we presented the results from Serenade this morning at Cape Town International Diabetes Federation meeting. To comment upon those results today, I have with me Dr. Marc Cluzel, who is the President of Sanofi Research, as well as Douglas Greene who is our Chief Medical Officer in the United States, and Antonio Tataranni who is our Medical Director of the Acomplia franchise.

So the format of today's call will be a brief presentation. We shall go through the key slides from this morning's presentation at Cape Town, and Douglas will comment upon them. And, following this brief presentation, we shall have a Q&A session and we shall take as many questions as time permits. So I shall turn the call over to Douglas now to comment upon the slides. And you have the slides on our website and I invite you to go through them on Sanofi-Aventis.com. Douglas.

DOUGLAS GREENE, SVP, CHIEF MEDICAL OFFICER, SANOFI-AVENTIS UNITED STATES, SANOFI-AVENTIS: Thank you, Sanjay. What I would like to do at this point is to take you through the slides that were presented in Cape Town, to review the results briefly with you.

The first slide simply shows the title of the study. And if we go to slide number two, this points out that there are many unmet medical needs in type 2 diabetes. It's associated with multiple cardiovascular risk factors, such as increased waist circumference, low HDL and high triglyceride, which results in cardiovascular disease being really rampant in type 2 diabetes.

Improvement in glycemic control, which is an important element of therapy with most current treatments, is often associated with weight gain which may actually mitigate some of the benefits that are achieved by improving blood glucose control. And so oral anti-diabetic agents that can improve hemoglobin A1c, or glucose control, and yet produce weight loss as well, really remain unavailable at the current time.

The next slide demonstrates, briefly, something about the mechanism of action of rimonabant. Rimonabant is a CB1 receptor antagonist. CB1 receptors are expressed in many tissues that are involved in the modulation of food intake and its subsequent metabolism in all of the important tissues. And it's been demonstrated quite clearly that the control of metabolism in tissues such as the [adipohside] or fat cells, liver, muscle, gastrointestinal tract and pancreas, in overweight patients with type 2 diabetes is deranged. And much of this derangement appears to be due to an over-activity of the endocannabinoid system, which is targeted by CB1 receptor blockade with rimonabant.

By way of background, if we go to the next slide, we previously studied the effect of rimonabant in type 2 diabetes in a study called RIO-Diabetes which has been recently published. And this demonstrated, that in patients with more advanced Diabetes, that is patients who were already on treatment with an oral anti-diabetic but were, nevertheless, poorly controlled, that the addition of rimonabant, compared to placebo, resulted in a consistent and persistent improvement in hemoglobin A1c of about 0.7% compared to placebo, which is in the range of most oral anti-diabetic treatments. But, again, these were patients who were already on background therapy with either Metformin or sulphonylurea.

If we go to the next slide we can see that the Serenade study that we're going to talk about today, is the next step in the development of rimonabant as a comprehensive therapy for cardiometabolic risk in patients who are overweight or obese, with risk factors including type 2 diabetes. So in this slide you see the completed RIO-Diabetes study on the left. The Serenade study, which we're going to talk about today, was performed in patients with type 2 diabetes who are not on treatment, who have not been on treatment, and so they are considered to be drug-naïve diabetic patients earlier in the course of type 2 diabetes.

Ongoing studies, as you know, are looking at effects of rimonabant in dyslipidemia. They're looking at, with the Arpeggio study in patients with type 2 diabetes, who are treated with insulin. Rapsodi is looking at patients who are pre-diabetic in order to determine whether or not rimonabant would prevent the development of diabetes. And the last three studies on this list, Stradivarius, Auditor and Crescendo, are designed to look at the effect of rimonabant on atherosclerosis and cardiovascular morbidity, mortality. So this just puts the current study in perspective in the overall development plan.

The next slide simply demonstrates that this was a multi-center, randomized, double-blind, placebo-controlled parallel group study, using rimonabant 20mg daily, which is the dose which is marketed in some countries and under review in others.

The next slide demonstrates the study design. Again, this was a randomized placebo-controlled study in which patients with type 2 diabetes, who were not currently on therapy, who had a hemoglobin A1c between seven and 10, were screened during a two-week period. They were then randomized to either placebo or rimonabant 20mg for a six month period, during which time they were also given instructions in a modest calorie reduction, 600 kilocalorie energy deficient compared to their current diet, and some recommendation for increased physical activity.

And there is one important point that, between days 90 and 120, if patients remained out of control, that is, their hemoglobin A1c was greater than 9%, the investigator was allowed to introduce rescue medication, which is really quite necessary in order to conduct placebo-controlled trials in type 2 diabetic patients who are not on other drug therapy.

The next slide reviews the purpose of the study to demonstrate the potential use of rimonabant as an agent to improve type 2 diabetes by improving hemoglobin A1c, producing weight loss and improving multiple cardiometabolic risk factors, such as waist circumference, low HDL and high triglyceride parameters where rimonabant has already been shown to be active in other studies.

The next slide reviews the inclusion criteria. These were quite broad. These were adults who had type 2 diabetes for at least two months and less than three years. That is relatively early in the course of type 2 diabetes, who had not previously been treated, except for allowance of insulin, for example, for during pregnancy or short-term hospitalization, or oral therapy for no longer than four months. And this had to be in the distant past; greater than six months prior to screening. Again, they had to have a hemoglobin A1c between seven and 10, and they had to have stable weight in the previous three months.

The next slide shows the study outcome measures, the primary endpoint which was used to calculate the sample size for the study with the absolute change in hemoglobin A1c from baseline to month six. The secondary endpoints included the percentage of patients achieving goal. A hemoglobin A1c 6.5% is the European recommendation. 7% is the American Diabetes recommendation.

The other secondary endpoints are shown here; body weight, fasting plasma glucose, fasting insulin and insulin sensitivity, or HOMA index, HDL and triglycerides and change in blood pressure. So this was designed then to look at the entire spectrum of cardiometabolic risk in type 2 diabetic patients.

The next slide shows the study demographics at baseline, the randomization [work]. The two, the placebo and rimonabant group, were well balanced. A couple of points. About half of the patients were male, half female. The majority were Caucasian. Despite the fact that weight or body -- or waist circumference was not an entrance criteria, the ma-

jority of these patients were overweight. They had an elevated BMI and an elevated waist circumference, which is somewhat characteristic of type 2 diabetes, where the vast majority are either overweight or obese. The hemoglobin A1c at baseline was close to 8, 7.9. And, as you would expect from the inclusion criteria, these were relatively early diabetic patients in that their duration of diabetes was a little more than one year.

The next slide demonstrates that we did achieve, in rolling patients who have multiple co-morbidities associated with type 2 diabetes and obesity, two thirds of the patients were hypertensive. Two thirds of the patients had elevated LBL cholesterol. About a third of them had a low HDL cholesterol, that's the good cholesterol, and about more than half of them had an elevation in triglyceride. Again, characteristic, the usual phenotype that's seen with type 2 diabetes.

Looking now at the study of results. We'll go through efficacy first. The next slide shows patients' disposition, and there are a couple of points I wanted to make here. The study involved about 280 patients. You can see on this slide the randomization scheme, how [many] patients were randomized and exposed to drug. I want to call your attention to some of the numbers highlighted in red. You can see that for the placebo group, of the 131 patients who were part of the intend-to-treat population, 14 required rescue medication, whereas, in the rimonabant group, of the 130 patients only four required rescue medication. The discontinuation rate was 15 patients in placebo, 27 patients in rimonabant, leaving 125 and 111 patients as completers.

The -- so the retention rate in this study was actually pretty good. 85% of the randomized patients actually completed the trial, which is characteristic of what you would expect to see in a study of type 2 diabetes patients.

The next slide shows the effect of rimonabant versus placebo on fasting plasma glucose. And, as you can see, there was a significant decrease in fasting plasma glucose of about 1 milimol in patients on rimonabant versus placebo. This was highly significant and was present at day 90, and then it increased at day 180.

The next slide shows the primary endpoint, hemoglobin A1c. You can see the two curves diverging, the blue for placebo, the orange for rimonabant, with a decrease of about 0.8% for the intend-to-treat population, last observation carried forward. In the rimonabant treated patients about a 0.3% drop. In the placebo patients for a difference of about 0.5% in hemoglobin A1c placebo-subtracted. This, again, is in the range that one normally expects to see in drugs which are approved as anti-diabetics.

This slide simply -- the next slide simply demonstrates the numbers, again, 7.9 at baseline, a 0.8 decrease in the active treatment group. Placebo-subtracted, is 0.51. And, importantly, as we've seen in other studies previously in type 2 diabetes with rimonabant, about half of the effect of the change in hemoglobin A1c by [anova] regression analysis was above and beyond that which can be attributed to the measured weight loss in the rimonabant group, again, consistently showing this weight independent effect on hemoglobin A1c. We've shown it in other studies for insulin resistance. We've shown it for HDL and triglyceride, consistent with the multiple actions of rimonabant, both centrally in the nervous system, and peripherally in the tissues that actually are involved in controlling metabolism peripherally.

The next slide shows that if you look at the sub-group of patients who had a higher hemoglobin A1c at baseline, this is those above 8.5%, the change -- the placebo-subtracted change for hemoglobin A1c was even more impressive. In excess of a 1% fall in hemoglobin A1c, which is consistent with the older studies of other anti-diabetics which had been done at a time when baseline hemoglobin A1c was higher. And so many labeled drugs had this kind of number, but it's important to recall that they were studied for approval at a time when hemoglobin A1c levels were higher because of the quality of diabetic control.

The next slide shows the percentage of patients that achieved the two goals of 7%, the American Diabetes Association goal, 6.5% the European target. And you can see that more than half the patients in the rimonabant group achieved the American Diabetes goal, compared to 35% in placebo. And there was the same, about a quarter of the patients achieved the more stringent European goal, on single therapy with rimonabant in patients early in their course of Diabetes. And this is a significant achievement.

The next slide demonstrates the expected changes in body weight and waist circumference, consistent with rimonabant's previously demonstrated activities, and clearly different from most other anti-diabetic therapies, such as insulin and sulphonylureas, and [Thyosolodene Diomes], which are associated with weight gain rather than weight loss.

We understand a little bit about the mechanism by which rimonabant works, and the next slide shows the changes in the measurement of the fat-derived hormone, called adiponectin, which is considered to be an important mechanism to achieve insulin sensitivity. It is also thought to have beneficial effects on blood vessels. And, as you can see, there was an increase in adiponectin, consistent with what we've seen with rimonabant in other studies, and is probably re-

sponsible for some of the insulin sensitivity improvement and also maybe a harbinger of improvement in vascular disease as well.

If you look on the next slide, measurements in insulin sensitivity using the HOMA-IR calculation, once again we can see, consistent with previous studies, a very significant improvement in insulin sensitivity produced by the peripheral effects of rimonabant compared to placebo.

We go to the next slide, we demonstrate here again the consistent HDL cholesterol improvement, which we have seen in every other study that we've looked at, with about a 10% improve -- increase in HDL cholesterol with rimonabant 20mg. The placebo-subtracted difference is about a 7% difference and, considering the durations of study, this is consistent with what we've seen in previous studies as well.

The next slide shows the improvement in triglyceride. Again, a 17% reduction in triglyceride compared to placebo; an important parameter [in] associated with type 2 diabetes and corrected here by the addition of rimonabant.

If we look at the next slide it shows changes in blood pressure. There was a trend for a reduction in systolic and diastolic blood pressure consistent with what we have seen in other studies. This was a smaller study and so these were trends, but did not achieve statistical significance but, nevertheless, are reassuring.

The next slide takes us into the consideration of the safety profile that we saw in this study. Overall, the safety profile was consistent with what we've seen in the past, which we found reassuring. This slide demonstrates the number of patients who had any adverse event, patients with serious adverse events and patients who discontinued due to adverse events; the last column. And I would call your attention to that. We've, again, seen, always seen, a slight increase in the percentage of patients who discontinue due to adverse events with rimonabant.

The next slide demonstrates the types of adverse events that we've seen. These are greater than 5% in any group. And, again, consistent with the previously demonstrated safety profile, some increase in dizziness, nausea, which is usually mild, self-limited, normally one episode of slight nausea for example. There is an imbalance as well, in this case in upper respiratory tract infections. We've not seen that previously. It may just be a play of chance. There is a slight increase in anxiety, a slight increase in depressed mood. And these are, again, consistent with the safety profile that we have previously reported.

If we focus down into the psychiatric disorder we see, again, a similar numerical imbalance that we've reported previously with one, I think, important and somewhat reassuring component here. Although there was an increase in the frequency of depressed mood, 5.8% versus 0.7%, in this study we had emphasized the need to evaluate depressed mood and depression in a consistent and rigorous way. And what we actually see, although, there is an increase in the frequency of depressed mood, there is no increase in cases of depression. And, in fact, there is a numerically smaller number of cases of depression in rimonabant 20mg, indicating that whatever we're seeing in this general area, seems to be mild and, perhaps, more of a tolerability issue than a safety issue.

The next slide looks at reasons for discontinuation. I'm sorry it's such a busy slide but with a small number of patients many of the discontinuations were just individual patients. You can see that there were 13 patients who discontinued in rimonabant due to adverse events, three in the placebo group, again, a few due to gastrointestinal disorders, nausea and vomiting. You can see the numbers here. They're very small and nothing new appearing as a safety signal at this point.

The next slide simply shows the, again, discontinuations. You can see the numbers. There were three for depressed mood. There were three for paraesthesia. This is not an unusual finding in patients with type 2 diabetes, especially, drug-naïve ones who are brought under improved metabolic control. They often times complain of mild paraesthesias. It's probably -- it's almost an indication of getting their feeling back in their feet and their legs.

To summarize, on the next slide, we saw a 0.8% reduction in hemoglobin A1c, a 1.9% reduction in hemoglobin A1c in patients whose HbA1c at baseline were greater than 8.5%, about a 6.7% -- a 6.7 kilogram reduction in body weight. That's almost 15 pounds. A 10% increase in HDL, 16% reduction in triglyceride, with a safety profile which is consistent with what we have previously seen in our larger Phase III studies.

Just for a little bit of commentary. To compare this and put this in perspective of the RIO-Diabetes study, we see here hemoglobin A1c comparisons to RIO-Diabetes at month six. And you can that the Serenade results are quite robust and consistent with what we had previously seen at the six month time point for -- in RIO-Diabetes, remembering that RIO-Diabetes is a 12 month trial.

Similarly, if we look at weight and waist circumference, and we compare them with the results of RIO-Diabetes at six months, the findings are perfectly consistent with what we have previously published in type 2 diabetes. And we look at the fact that rimonabant in this disease, then, is producing a significant fall in hemoglobin A1c. At the same time it's producing a significant fall in body weight in these overweight patients which really, I think, represents -- addresses an unmet medical need.

And so, to conclude, rimonabant achieved its primary endpoint of clinically significant reduction in hemoglobin A1c, and also improvements in body weight and waist circumference with improved lipids and adiponectin levels. And so we believe that this demonstrates that rimonabant will offer an important new approach to the initial management of type 2 diabetes addressing weight, hemoglobin A1c and multiple cardiometabolic risk factors. And that, obviously, we're continuing to do further studies to fully understand how rimonabant should be best used, as a new addition to the whole anti-diabetic management that's evolving so quickly.

So, with that, I'd like to conclude and would like to turn it back to the operator for further questions.

OPERATOR: Thank you. The question and answer session will be conducted electronically. [OPERATOR INSTRUCTIONS]. We will take our first question from Andy Kocen from Redburn. Please go ahead, sir.

ANDY KOCEN, ANALYST, REDBURN: Hello there, a couple on the regulatory side and then one on the trial. First of all, is this trial sufficient as a registration trial for first line treatment of type 2 diabetes in Europe and the U.S.?

The second one is on the U.S. data re-filing. Are you able to comment now whether you've got an end December or end April action date?

And, then on the study we've seen today, could you talk in more detail about the difference between depressed mood and depression, how you evaluated that, how regulators see both of those adverse events? Thanks.

DOUGLAS GREENE: Sure. The first question, this is a well-controlled randomized clinical trial, of the size which is normally used to study anti-diabetic effects in type 2 diabetes. I think that it met its primary endpoint, so I think it's certainly a trial which would be considered to be a demonstration of improved hemoglobin A1c in type 2 diabetes.

Whether or not the specific labeling language which would be derived from this would be the result of this trial, [that's] embedded in the overall program, I really can't speak for the FDA or other health agencies as to what kind of labeling would specifically derive from this trial.

With regard to your second question, I'm really -- you know we're under review and we -- we're really not in a position to make any conjectures with regard to what the review will -- how it will evolve and so forth. I think it would be -- we're just not going to make those kinds of comments.

With regard to the assessment of depressed mood versus depression, I don't want to get into the complexities of the different MEDRA codes that are used to collect adverse events. Suffice it to say that these are terms that investigators apply to their patients. They are well defined in our -- in the dictionary of adverse events. Regulators pay strict attention to this kind of differentiation.

Depressed mood is more of an indication of feeling sad, a patient who might say, well, I feel sad or I don't feel happy. Whereas diagnosing it as a case of depression is more of a medical diagnosis in which a physician would assess the fact that the patient is actually depressed. And so we have refined our definitions. We've encouraged investigators to look at this very carefully and this is the results that we have. And we do think that this is -- that regulators do recognize this difference.

ANDY KOCEN: So in terms of the depression, we should be looking at the lower set of figures for Acomplia in terms of comparing to the European label, and looking at the more serious, rather just dysthymic side effects that the medical -- the psychiatric disorder?

DOUGLAS GREENE: Not sure I understand. Could you repeat the --

ANDY KOCEN: Sorry. I mean the European label, for example, lists the incidents of depression as 3.2% with Acomplia versus 1.6 I think it was with placebo.

DOUGLAS GREENE: Yes.

ANDY KOCEN: We -- the comparable figure from this trial should be -- shouldn't be the 5.8. It should be the, I can't remember, 2.4. Or is it slightly different then because you've mentioned definition?

DOUGLAS GREENE: I think we've refined the way that we've asked investigators and instructed investigators to report this. So I think you have to take each trial on its own merits, and that's why we have a placebo group. And so what I think this demonstrates, at least in my way of thinking, is that whatever we're seeing in this realm is relatively mild. We'd said it before that we thought it was mild and self-limiting. The fact that we see the imbalance in depressed mood and we don't see it in depression just -- it's reassuring.

DR. MARC CLUZEL, PRESIDENT, SANOFI RESEARCH, SANOFI-AVENTIS: Marc Cluzel speaking. Just the initial round of three-year study was much larger than this one. And so, so far, I think the true reference is still the RIO program, so what is in the European label. Serenade is going in the same direction so it's, as Doug said, there is nothing more to add. But you know we are strictly monitored by the European agencies, so if there was any kind of increase in terms of reporting, it will be included into our label.

ANDY KOCEN: Okay, thanks very much.

SANJAY GUPTA: Could we have the next question please?

OPERATOR: Our next question comes from Andrew Baum from Morgan Stanley. Please go ahead.

ANDREW BAUM, ANALYST, MORGAN STANLEY: Good afternoon, gentlemen. Three questions, if I may. The first, perhaps, you could tell us the percentage of patients in Serenade who had a previous history of depression? I know the exclusion criteria were different from the RIO trials. But that would be number one.

Number two would be how the FDA sees your definition of [weight] independence, whether your statistical methodology you've adopted derived at the 57% figure, or 50%, is something that's entirely accepted or whether something that there's an active dialog on?

And then, finally, you might like to tell us the anticipated filing time for Serenade with the regulatory agencies. In addition, when we expect to see Serenade published in a peer review journal.

DOUGLAS GREENE: Okay. The -- your first question was how many patients were censored for depression.

ANDREW BAUM: Not censored. I understand from, if my memory serves me correctly, from the RIO META analysis there are about 6% of patients who got into the trial despite the fact they had a previous history of depression. Now here the exclusion criteria are a little bit more vague but, perhaps, you have some record of what percentage would meet those, or similar, criteria?

ANTONIO TATARANNI, MEDICAL DIRECTOR, ACOMPLIA FRANCHISE, SANOFI-AVENTIS: Andy, if you don't mind, I'll take this one.

DOUGLAS GREENE: Go ahead, Antonio.

DR. MARC CLUZEL: Go.

ANTONIO TATARANNI: [Dr.] Tataranni speaking. So the percentage of people in Serenade that made it into the trial and carried a diagnosis of depressive disorder was 8.6% in the placebo group, and 6.5% in the rimonabant 20mg group. People with a milder form of mood disorders was 2.9 the placebo group, and 0.7% in the rimonabant group.

ANDREW BAUM: And by this you mean historically rather than active disease? Correct?

ANTONIO TATARANNI: No, I mean active disease while being treated with rimonabant.

ANDREW BAUM: I don't -- I'm sorry, it's just maybe I wasn't clear. I meant at the start of the trial, so not during the course of therapy. So, how many patients who entered the trial had a previous history of depression in both groups?

ANTONIO TATARANNI: Those are the numbers, those are --

ANDREW BAUM: So this is a baseline, the baseline?

ANTONIO TATARANNI: Yes.

ANDREW BAUM: Okay, thank you. The second question was on the FDA's view of your statistical methodology for claiming weight independence, and whether this is something that's firmly agreed in guidelines, or whether there is some active dialogue between you and the regulation --you and the FDA?

DOUGLAS GREENE: There are no guidelines to demonstrate weight loss independence. I think that rimonabant is the first -- it's the -- certainly the CB1 receptor antagonist, seems to be the first mechanism that has demonstrated this kind of effect. So, there are no guidelines. As you know, it's the Europeans who are very enthusiastic about this, and it was highlighted in our European label.

We -- the way we achieve that, in the European label, was not simply with a statistical analysis, it was the entire body of evidence, which included a statistical analysis. It included looking at sub-groups. It included looking at different categories of weight change, and demonstrating the weight loss independent effect. Some of the studies that were done in smokers, where body weight change didn't occur but we, nevertheless, saw changes in lipids, again, was part of this whole growing body of evidence.

So I think that it is first of all not dependant on, totally a statistical measure, but rather as more a complete body of evidence. As I've said, it's highly highlighted in our European label. And, although I can't speak at this point for the FDA they've, obviously, seen the same kind of analysis and the same kind of data.

DR. MARC CLUZEL: I also want to add something, you know that obesity or increase the body weight was not an inclusion criteria. So, we got to close to 30 patients without the increase of BMI. And in this population, we got a decrease of HbA1c in the sum or range of magnitude to 0.7 to 8%, and without body weight loss. But still -- so we have an anti-diabetic effect obviously without too much anti-obesity effect. So, it's not a definitive answer, but its growing evidence that we acting on top of body weight loss.

ANDREW BAUM: Thank you, and the final question was on anticipated filing time for the Serenade data, and peer review journal publication.

DOUGLAS GREENE: We -- certainly we've published our data fairly quickly, I think given the fact that we published all four RIO studies before, or shortly around, the time of approval. And we will obviously be as rigorous with Serenade as doing that. We are really not, at this point, -- the results are sort of hot off the press, and we really haven't discussed exactly when we are going to be submitting these to various health authorities. But we are obviously thinking and discussing that quite actively.

ANDREW BAUM: Thank you.

OPERATOR: Our next question comes from Jo Walton from Lehman brothers, please go ahead.

JO WALTON, ANALYST, LEHMAN BROTHERS: Two questions, one goes back to the filing of this data. I am just trying to ascertain whether you would expect to be able to get a diabetes claim from this data in addition. So, just to clarify, you as expecting to be able to get a [label] change in Europe, where the drug is approved, and you'd expect this to make a difference to your label in the U.S.?

And in -- on the issue of depression, I am sorry to go back to that. But do you have any data on whether patients required concomitant medication, whether there was a higher use of anti-depressants? I am trying to get some sense, again, of how serious this depression side effect is.

DOUGLAS GREENE: Okay, so your first question is -- your first two questions deal with the labeling impact of this study. I certainly believe that this is another piece of evidence in an additional population of type 2 diabetes, demonstrating anti-diabetic effect. Most anti-diabetic drugs, drugs which have got an anti-diabetes indication, were developed specifically for that purpose, and are studied in a variety of different kinds of populations.

The history of rimonabant is a little bit different. It was -- it's looked at in a broader context, addressing multiple cardiometabolic risks, including type 2 diabetes. And so, exactly how and when that will be captured in a label, I think, is going to be specific to rimonabant and to the total totality of evidence that we have. So, I think I can't really speculate on that. We certainly think this is a very important step forward. And we certainly think that this is of the quality of, and weight of evidence, that you would see in an anti-diabetic trial in this patient population. So, that's really all I think I can say at the moment.

With regard to the use of anti-depressants within the study, Antonio do you have that information, because I don't really think I do?

ANTONIO TATARANNI: Yes, I have some degree of initial information. We are still looking into the data, but the -- I have information about the concomitant use of psycholeptics which will have included anti-depressants. And

that use is approximately 12% in the people that were treated with rimonabant 20mg, versus 3.6 to 4% in the people that were in the rimonabant group. And we'll continue to gather more details as we go on with the analysis of the data.

JO WALTON: Can I just also ask, with the six month study, is there any suggestion that the problem occurs early on, people then are happier, therefore, this was skewed? Or are you giving me the usage at that end point? So, presumably one would assume that it has built up this level by six months.

DOUGLAS GREENE: I think, the first thing that I would say, if you want to look at time course, I think the best place to look at that is in what we've published with the two year studies. And in those two year studies, when you look at the question of depression and depressed mood, in the second year there is no difference from placebo. So I think, again, you are right in saying this is a short study, and probably not the best place to look at that question. But I think the longer studies are -- speak for themselves.

DR. MARC CLUZEL: Yes, still also Jo, you have to remember that it was a simulated question specifically about depressed mood. So, from where you know that when you are asking if you have something you always increase the number of reporting. So, I don't think that the study is down-sizing the event.

JO WALTON: Thank you.

OPERATOR: Our next question comes from Sebastien Berthon from Exane, please go ahead.

SEBASTIEN BERTHON, ANALYST, BNP PARIBAS: Hello gentlemen, three questions please, the first one is the requirements for filing in Europe, sorry to come back to that again. But the EMEA stated they wanted mono-therapy in untreated patients, but also a study in patients failing another OAD. Is that still the case, or is it the possibility that, the mono-therapy only study could be sufficient for you to get a label impact in Europe?

Secondly, with regards to your reimbursement discussions, to what extent does the Serenade results affect these discussions? Or, nothing can change until you have any label change in Europe, and are there any differences from country to country?

And lastly, could you come back to the -- just to tell us whether you have had an answer from the [FDA], whether you have a class one or class two review? Thank you.

DOUGLAS GREENE: Okay, I am not sure of your first -- of your first statement. We filed in Europe. We had filed with a study, essentially two studies, RIO diabetes with patients failing two classes of oral anti-diabetic either failing Metformin or failing sulphonylurea. And there was an interest in demonstrating that rimonabant also had an effect on HbA1c in the absence of background therapy that is demonstrating that its anti-diabetic effect wasn't in some way dependant on having some sort of background therapy. We think we've achieved that in the Serenade study. The exact -- we certainly will have discussions about this growing body of evidence with European regulators. We haven't had those discussions at this point. Again, the data are hot off the press.

With regard to reimbursement you, and I think you specifically said reimbursement in Europe, in some countries we've already achieved reimbursement, in some countries it's still under discussion. And we think, for sure, that this will be another important demonstration of medical benefit that will have a positive impact on those discussions.

With regard to our status with FDA you know we have re-filed. And the agency has our response to their approvable letter. They are looking at it even as we speak and I really can't say anything else at this point, about that process.

DR. MARC CLUZEL: I'd like to add something. In terms of positioning of the drug, it is clear that we have very nice result today [inhibitors] with a population of [8.5] with close to 2% so really a true anti-diabetic. Still, the positioning of Acomplia is not exactly -- or rimonabant, is not exactly [inhibitors].

We never want, and we never said that we wanted a full indication anti-diabetic. We wanted -- we want a level which is taking into account the metabolic and cardiovascular effect of Acomplia on rimonabant in patients with overweight [and BMI] with associated metabolic risk factor parameters. And, in fact, the corner stone of our program is definitely Crescendo looking, in fact, at the reduction of [the morbidity] in this specific population.

SEBASTIEN BERTHON: Thank you.

OPERATOR: Our next question comes from Alexandra Hauber from Bear Stearns, please go ahead.

ALEXANDRA HAUBER, ANALYST, BEAR STEARNS: Thank you very much I have three questions, first of all coming back again on the depression. Could you just tell us how you managed depression in the trial, because I was

under the impression that in the previous trial you were looking carefully during the trial at these patients, looking at their [total] anxiety depression score? Did you do a similar thing in Serenade?

Secondly, just coming back to the point of this weight independence, and I am still a bit puzzled about the fact, particularly, also in view of the comment in the Lancet a few weeks ago, which pointed out that this is very much a black box which requires number of assumptions. So, therefore, I am quite intrigued that you are saying that you are seeing something in patients who actually don't lose weight.

So, will you -- will the peer review publication, will that include that a sort of sub-group analysis where we could see that difference? Or, alternatively, are you planning to conduct a trial in a real life setting, that is in patients who do not diet and exercise to see whether we could get a similar result?

And the just a third question is in terms of the retention rates. Have we -- can you just compare those retention rates to the six month retention rates from the other trials, because there we obviously haven't seen the retention rates after six months, just after one and two years?

DR. MARC CLUZEL: I can take the point about the group without weight loss. You know that in our smoking cessation program we had patients without high BMI, and we showed that we are not acting on the weight of this patient. We have no activity. And, in fact, as I said we just can say that obesity or BMI was not an inclusion criteria, so we got a sub-group of patient without overweight. And in this group the decrease of HbA1c was comparable to the whole population, period. And, in fact, also in this population since they were lean people, they did not need to lose weight, so they didn't lose weight.

ALEXANDRA HAUBER: But they still did diet and exercise.

DR. MARC CLUZEL: Of course, but what you are proposing is something which is not totally ethical. The first treatment of the diabetes is to practice exercise and to have diet. So, I do not see how we can do --

ALEXANDRA HAUBER: So, are you suggesting that the Serenade --

DR. MARC CLUZEL: Sorry.

ALEXANDRA HAUBER: Are you suggesting that the conditions were totally normal of any normal anti-diabetics, are they doing also 600 [kilo] calorie diet?

DR. MARC CLUZEL: Of course --

DOUGLAS GREENE: Let me just correct a point, the 600 kilocal, and Antonio you can validate this, the 600 kilo calorie reduction was applied to 96% of the patients who were overweight. The patients who were not overweight, although they were encouraged to exercise which is part of the normal treatment of type 2 diabetes, they were encouraged to eat a prudent diet, they were not given the weight loss prescription as part of -- for their diet prescription. So that, and thank you for pointing that out, because the slide is a little bit wrong in what it says minus 600 kilo calorie that was for the patients who were overweight or obese at baseline, not this other 4%.

ALEXANDRA HAUBER: So, we have 10 patients overall who were not overweight, and I presume there were equal --

DOUGLAS GREENE: I think it is 14 if I remember the number correctly.

ANTONIO TATARANNI: It is 10 patients if we cut the data by the definition of a BMI below 25. It's six in the rimonabant group and four in the placebo group.

DOUGLAS GREENE: With regard to --

DR. MARC CLUZEL: Below 27 it was 14 patients in the placebo arm and 15 in the rimonabant.

DOUGLAS GREENE: That's correct.

DR. MARC CLUZEL: So, 39 patients without overweight as a definition as a cut off of 27.

ALEXANDRA HAUBER: Okay.

DOUGLAS GREENE: With regard to whether we did the HAD scale, we did not do the HAD in this study. We did have a [inaudible] special care for adverse event reporting, there were stimulated questions about mood. So that at each visit, the patient was asked specific questions about changes in mood and so forth and so on. So, it was an active ascer-

tainment. And, as I think Marc said earlier, when you ask proactively about any adverse event you usually see a slightly higher frequency than if you don't ask. So that's why we think it's important to do the placebo control rather than looking at the absolute numbers.

ALEXANDRA HAUBER: Right, thank you, and on the discontinuation rates?

DOUGLAS GREENE: What was your question on discontinuation?

ALEXANDRA HAUBER: I think we haven't seen previously discontinuation rates for six months, just simply because -- so could you just contrast roughly how they would compare to your previous trials, where we only saw the one year discontinuation rates?

DOUGLAS GREENE: That's a very --

ALEXANDRA HAUBER: Is a lot of that happening in the [second to two] months.

DOUGLAS GREENE: That's a very pertinent question, unfortunately, I don't -- we don't have the data at this point. We haven't had the time to go back to re-evaluate and cut the data again to see the discontinuation rates at six months for example.

DR. MARC CLUZEL: If I remember correctly RIO was a discontinuation rate of 30%, close to 30%. And the difference of placebo we have an increase of discontinuation rate during the initial four months. And after that it has a tendency to plateau when the -- when, in fact for placebo is [inaudible], so with a crossing at one year. So, I will expect to a little -- [we are well] in the range of RIO.

ALEXANDRA HAUBER: Okay, thank you.

OPERATOR: Our next question comes from Michael Leacock from ABN Amro, please go ahead.

MICHAEL LEACOCK, ANALYST, ABN AMRO: Thank you, I have two brief questions if I may? Firstly, can I just be absolutely clear what indication you think this data supports? Will you be going, at some point, to a straight indication for the treatment of diabetes or is it going to be a strengthening of the risk factor indication?

And secondly, I wonder if you can talk a little bit about the paraesthesia issue, particularly, with the discontinuations in this study? And we didn't see much paraesthesia, 0.6% I think in RIO diabetes, and clearly over a longer period of time. Could you talk a bit about the -- what actually you are seeing, and what your mechanism of action might be for this adverse event being seen in the rimonabant group, but not in the placebo?

DOUGLAS GREENE: Well, with regard to the indication that we might seek, I think, we recognize that this is -- rimonabant is a different, it's a unique pattern of activity pharmacologically. I am really not prepared to speculate on how this would be best captured within a label. I know that's something that everyone thinks is important, but we are breaking new ground here and I am not -- there are a variety of ways that this could be incorporated into a label. You mention a separate indication for type 2 diabetes. Marc mentioned the concept of rolling this into cardiometabolic risk, as an important risk factor. I am not sure what the outcome of those discussions will be, and what the best way is to capture that into an indication. I just don't think it's worth speculation.

The paraesthesias are actually quite interesting, when -- with many different kinds of anti-diabetic drugs. If you take people who are badly controlled, and not on any medication and you bring them under control, the fact that you re-stabilize them in a normal glucose environment, they frequently get these -- an increase in paraesthesias. It's actually an indication -- it's another measure of the fact that they've had metabolic improvement. These usually are transient and some people argue that this is -- that they are actually regaining some of the sensation that they lost during the time of bad diabetes control. So that's the way we are looking at it.

In RIO diabetes these people were already on anti-diabetic therapy before they started the study. In this situation these patients were not on any therapy, any medical therapy, and we introduced the therapy. So, I don't think it's an unexpected finding.

MICHAEL LEACOCK: It sounds to me more that you are reporting that as a beneficial effect rather than an adverse effect.

DOUGLAS GREENE: Well, it depends. I've treated diabetic patients for 30 years. If you wanted to tell them this was a benefit I do -- sometimes you do. You say the fact that you are getting this means that you are coming into better

control. Whether they like the feeling or not is a separate issue. So we report it as it's reported to the investigators, and it will be listed as you saw it on the slides.

MICHAEL LEACOCK: Thank you very much.

OPERATOR: Our next question comes from Beatrice Muzard of IXIS Securities, please go ahead.

BEATRICE MUZARD, ANALYST, IXIS SECURITIES: Good afternoon gentlemen. Actually most of my questions have been answered, but I have an additional one. Could you update us with the take off of Acomplia in the U.K., the Scandinavian countries and, more importantly, in Germany please?

SANJAY GUPTA: I think we cannot go beyond what we have revealed on our Q3 conference call. Basically, we presented to you data which shows that Acomplia in the U.K. was amongst the best six launches in that country. The launch so far in other countries, specifically in Germany, is on expectations. And we shall provide an update at our half year results. So, we cannot comment further on the commercial success of Acomplia beyond the Q3 result.

BEATRICE MUZARD: Okay, thank you.

OPERATOR: Our next question comes from Paul Mann from Deutsche Bank, please go ahead.

PAUL MANN, ANALYST, DEUTSCHE BANK: I just have a couple of questions, first of all in the patients who had the high baseline HbA1c. Could you tell us exactly what the weight loss exhibited in those patients were and what the starting weight of those patients was?

And also, mentioning in the broader population, there was independent [learning] of HbA1c was [something like] about 59% or so. Was it the same number throughout the group? Or did you see more independent HbA1c [learning] in this higher [group of] patients?

And then also, just quickly onto the interpretation of [proving yourself], you said that your placebo adjusted, placebo to [HbA1c] [learning] was, at 0.5%, is comparable to other diabetes products. I notice you are using a lower starting [HbO] than seen in other non-approved mono-therapy. Could you just [inaudible] mono-therapies have been approved [in a similar] or with that kind of level of 0.5%?

DOUGLAS GREENE: The first -- your first question is whether the high HbA1c patients had a different starting weight. I haven't seen that calculation, I don't know, Antonio have you?

ANTONIO TATARANNI: Yes, I do have the numbers. So, the starting body weight was comparable to the rest of the population, in the range of 98kgms for both groups. And the drops, both in the placebo group and in the rimonabant 20mgs group were also very comparable; a drop of 3 kilos in the placebo group and 7 kilos in the rimonabant 20mg group, or a placebo subtracted effect of minus 4.1, which is completely in line with the rest of the population.

PAUL MANN: Yes, thanks.

DOUGLAS GREENE: With regard to the weight independent effect, I am not --

PAUL MANN: [There seemed to be] a very small number of patients it's difficult to get answers, but a significant [inaudible] was there any indication?

DOUGLAS GREENE: So your question is whether the high hemoglobin -- whether the weight independent effect was greater with the higher hemoglobin A1c patients?

PAUL MANN: That's right yes, or lower.

DOUGLAS GREENE: I haven't seen that analysis. I don't think we -- we haven't gone back and done regression analysis in multiple sub-groups because, as you get to smaller and smaller numbers, it becomes more and more difficult at [reaching].

With regard to -- it's very difficult to draw cross-trial comparisons on the absolute magnitude of hemoglobin A1c fall. That's why we've tried to segment this out within a single study. It's confounded by the rescue medication. It's confounded by differences in baseline.

As you know, many of the mono-therapy studies that were done previously for drug approval were done on drug-withdrawn patients, not on drug-naïve patients. And in that setting what you see is a placebo group that goes up, be-

cause you've withdrawn them from another drug. Those studies are no longer considered as appropriate ways to study the question of mono-therapy in drug-naive patients.

And so I would just caution you about making these kinds of cross-study comparisons with other peoples' labels that may have had studies that were done many, many years ago. This was not the usual mono-therapy study when you take people on therapy you discontinue them, you wash them out, and then you put them back on treatment. This was a true mono-therapy study in people who were not on background therapy, who were essentially drug naive.

DR. MARC CLUZEL: Also in terms of the extent of the activity, you have to remember that after three months the people not [calibrated] were removed from the study. So, if you are doing -- if you have a study without this kind of different impact, you can increase the difference versus placebo at the end.

PAUL MANN: Okay, thanks very much.

SANJAY GUPTA: Operator, I think we have time for a last couple of questions.

OPERATOR: Our next question comes from Graham Parry from Merrill Lynch. Please go ahead.

GRAHAM PARRY, ANALYST, MERRILL LYNCH: Most of my questions were asked, but I was just wondering do you have a breakout of the HbA1c lowering effect, in obese versus non-obese patients and overweight versus non-overweight patients? So, is there any difference in the HbA1c effect whether the patients are overweight or not, thanks?

DR. MARC CLUZEL: I think I answered the question already, or I missed -- said that not overweight patients over -- in the 39 patients whose BMI is below 27, and so 14 in placebo and 15 on rimonabant. The decrease of HbA1c was 0.78, which is exactly in the same order of magnitude of the global result, which is 0.8.

GRAHAM PARRY: Okay, that's great thanks.

SANJAY GUPTA: Okay, so can we have the last question please?

OPERATOR: We have no further question at this moment.

SANJAY GUPTA: Perfect. We would like to thank you, and end the call here. We would like to thank you all for attending. If you have any further questions please don't hesitate to call Investor Relations. Thank you Doug. Thank you Antonio. Goodbye.

OPERATOR: That will conclude today's conference call. Thank you for your participation, ladies and gentlemen. You may now disconnect.

[Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.]

Exhibit Y



sanofi aventis

Because health matters

NEW DATA SHOWS ACOMPLIA® (RIMONABANT) BENEFITED PATIENTS WITH TYPE 2 DIABETES BY IMPROVING BLOOD SUGAR CONTROL, REDUCING WEIGHT AND ACTING ON OTHER CARDIOMETABOLIC RISK FACTORS

- First Rimonabant Trial with HbA1c as a Primary Endpoint -

Cape Town, South Africa - December 5, 2006 - Sanofi-aventis announced today that new data on rimonabant, its first-in-class cannabinoid type 1 (CB1) receptor blocker, showed that patients with type 2 diabetes not currently treated with anti-diabetic medications experienced significant improvements in blood sugar control and weight as well as other risk factors such as HDL-cholesterol (good cholesterol) and triglycerides when compared to placebo. The study, called SERENADE, was presented today at the International Diabetes Federation (IDF) World Diabetes Congress in Cape Town, South Africa. SERENADE is the second study demonstrating that rimonabant significantly improved blood sugar levels in people with type 2 diabetes.

In the SERENADE study, treatment-naïve type 2 diabetes patients receiving rimonabant 20mg per day for a duration of six months significantly lowered their HbA1c levels by 0.8% from a baseline value of 7.9 as compared to a reduction of 0.3% in the placebo group ($p=0.002$). In addition, patients with an HbA1c level greater than or equal to 8.5% at baseline, significantly reduced their HbA1c by 1.9% with rimonabant as compared to 0.7% with placebo ($p<0.0009$). Over 50% of patients in the rimonabant arm of the trial achieved HbA1c levels below 7%, the target for good glucose control as recommended by the American Diabetes Association (ADA).ⁱ Importantly, these improvements in blood glucose control were accompanied by significant and clinically meaningful reductions in body weight of 6.7 kg (14.8 lbs) in patients treated with rimonabant 20 mg, while those patients on placebo lost only 2.7 kg (5.95 lbs) ($p<0.0001$).

"The management of type 2 diabetes should not only focus on controlling blood sugar levels but also improve other risk factors such as weight, good and bad cholesterol, triglycerides and blood pressure," said Julio Rosenstock, M.D., Director of the Dallas Diabetes and Endocrine Center at Medical City and also Clinical Professor of Medicine at the University of Texas Southwestern Medical School, Dallas, Texas who was an investigator in the SERENADE trial. "This study suggests that rimonabant can achieve improvement in blood glucose with the added benefit of significant weight loss and improvement in other risk factors."

Press Release



sanofi aventis

Because health matters

Today, more than 194 million adults or 5% of adults worldwide have been diagnosed with diabetes, with type 2 diabetes constituting 85-95% of all diabetes in developed countries.¹ Approximately 90 percent of type 2 diabetes is attributed to people being overweight or obese.² Diabetes and obesity are often associated with other risk factors for cardiovascular disease including high blood pressure and unhealthy cholesterol. Worldwide, diabetes is among the leading causes of blindness, renal failure and lower limb amputation, as well as death through its effects on cardiovascular disease (70-80 percent of people with diabetes die of cardiovascular disease).³

Accompanying the improvements in HbA1c and weight seen in the rimonabant arm of the SERENADE trial were improvements in multiple cardiometabolic risk factors. Patients in the rimonabant arm decreased their waist circumference (a measure of abdominal obesity) by 6.1 cm (2.34 in) compared to a 2.4 cm (0.93 in) decrease for patients on placebo (p<0.0001). HDL-cholesterol or "good" cholesterol increased by 10.1% compared to 3.2% for patients on placebo (p<0.0001). Triglyceride levels (bad fats in the blood) decreased by 16.3% compared to a 4.4% increase for placebo (p=0.0031). There was a trend toward reduction in systolic blood pressure by 5 mmHg and diastolic blood pressure by 1.2 mmHg in the rimonabant 20 mg arm compared to a 2.2 mm Hg decrease in systolic blood pressure and an increase of 0.1 mm Hg in diastolic pressure in the placebo arm (p=NS). Fasting Plasma Glucose decreased by 0.9 mmol/L (16.2 mg/dL) in the rimonabant 20 mg arm compared to a 0.1 mmol/L (1.8 mg/dL) increase in the placebo arm (p=0.0012). Adiponectin, a protein associated with reduced risk of diabetes and heart disease when present in high levels, increased by 1.6 µg/mL in the rimonabant 20 mg arm compared to a decrease of 0.2 µg/mL in the placebo arm (p=0.0001).

Approximately 57% of the improvements in HbA1C (p<0.001) were independent of the weight loss achieved, suggesting a direct effect of rimonabant on this parameter.

The overactivity of the Endocannabinoid System (ECS) in the fat tissue and muscle is found to promote fat accumulation and decrease glucose uptake, which can lead to an increased risk of developing insulin resistance and impaired glucose tolerance. By selectively blocking CB1 receptors of the ECS, which according to animal and human studies can be found in the brain, fat tissue, gastrointestinal tract, pancreas, liver and muscle, rimonabant results in a decrease in food intake, a loss of body weight, and direct improvements in blood sugars (HbA1c), HDL-cholesterol and triglycerides.

"Some current medications for type 2 diabetes are often associated with weight gain," said Julio Rosenstock. "The fact that blood sugar levels were reduced along with weight loss and improvements in HDL-cholesterol ("good" cholesterol) and triglycerides may further support the novel mechanism of action of rimonabant, which is different from the mode of action of current oral anti-diabetic medications."

Press Release



sanofi aventis

Because health matters

Press Release

The most common side effects with placebo and rimonabant 20 mg reported in the SERENADE trial were dizziness (2.1% vs. 10.9%), nausea (3.6% vs. 8.7%), nasopharyngitis (7.9% vs. 7.2%), upper respiratory tract infection (2.7 % vs. 7.2%), anxiety (3.6% vs. 5.8%), depressed mood (0.7% vs. 5.8%), and headache (6.4% vs. 3.6%). The rate of serious adverse events was 3.6% for patients in the placebo arm versus 6.5% for patients in the rimonabant 20 mg.

Overall, discontinuation rates due to adverse events in the trial were 2.1% in placebo-treated patients versus 9.4% for patients on rimonabant 20 mg. The most common adverse events leading to discontinuation for the placebo and rimonabant 20 mg patients, respectively, were nausea (0% vs. 2.2%), depressed mood disorder (0% vs. 2.2%) and paraesthesia (0% vs. 2.2%).

About SERENADE

SERENADE (Study Evaluating Rimonabant Efficacy in Drug-NAive DiabEtic Patients) was a multi-centre, randomised, double-blind, placebo-controlled, parallel-group study comparing rimonabant 20 mg once daily to placebo in improving blood sugar control (as indicated by HbA1c) in treatment-naive type 2 diabetic patients not adequately controlled by diet alone for a period of six months.

The study was conducted on 278 patients at 56 study centres in the United States, Germany, Argentina, Chile, Hungary, Poland and the Netherlands. The primary endpoint of the trial was change from baseline of HbA1c levels. Secondary endpoints included weight and waist circumference, a key marker of intra-abdominal adiposity, fasting plasma glucose, lipid parameters and arterial blood pressure.

To be included in the trial patients had to have a diagnosis of type 2 diabetes for at least two months but less than three years, HbA1c levels greater than 7% and less than 10%, and could not have been treated previously with an anti-diabetic medication within six months prior to screening.

SERENADE is part of an extensive worldwide Phase IIIb clinical trial programme involving over 22,000 patients in eight studies, which will investigate the role of rimonabant in the treatment of type 2 diabetes and cardiovascular disease.

About Rimonabant

In Europe, rimonabant, known as ACOMPLIA[®] is approved as an adjunct to diet and exercise for the treatment of obese patients (BMI \geq 30kg/m²), or overweight patients (BMI $>$ 27kg/m²) with associated risk factors, such as type 2 diabetes or dyslipidaemia.

Rimonabant is currently commercialised in the United Kingdom, Germany, Denmark, Sweden, Finland, Norway, Ireland, Argentina and Austria.

At the end of October 2006, sanofi-aventis submitted a complete response to the U.S. Food and Drug Administration (FDA) approvable letter received in February 2006.



sanofi aventis

Because health matters

About sanofi-aventis

Sanofi-aventis is the world's third largest pharmaceutical company, ranking number one in Europe. Backed by a world-class R&D organization, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine, and vaccines. Sanofi-aventis is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expects," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

Onsite Media Contact:

Nazira Amra: +33 6 30 32 63 15

US Media Relations:

Julissa Viana: +1 908-981-6575

References:

ⁱ American Diabetes Association. Standards of Medical Care in Diabetes 2006. *Diabetes Care* 2006;29:S4-42.

ⁱⁱ The International Diabetes Federation Diabetes Atlas. Available at: <http://www.idf.org/home/index.cfm?unode=3B96906B-C026-2FD3-87B73F80BC22682A>. Last Accessed November 15th, 2006.

ⁱⁱⁱ World Health Organization, <http://www.diabetes.org/diabetes-heart-disease-stroke.jsp>. Last accessed 11/17/08 /p2/Line 63-64

Press Release

Exhibit Z



RIMONABANT UPDATE IN THE UNITED STATES

Paris – December 8, 2006 – Sanofi-aventis announces that concerning the New Drug Application for rimonabant in the United States, the Food and Drug Administration has considered its October 26, 2006 resubmission to be a complete, class 2 response to the FDA February 17, 2006 action letter.

The user fee goal date is April 26, 2007.

About Rimonabant

Rimonabant is a first-in-class cannabinoid type 1 (CB1) receptor blocker discovered and developed by sanofi-aventis.

In Europe, rimonabant, known as ACOMPLIA® is approved as an adjunct to diet and exercise for the treatment of obese patients (BMI ≥ 30 kg/m²), or overweight patients (BMI > 27 kg/m²) with associated risk factors, such as type 2 diabetes or dyslipidaemia.

Rimonabant is currently commercialized in the United Kingdom, Germany, Denmark, Sweden, Finland, Norway, Ireland, Argentina and Austria.

About sanofi-aventis

Sanofi-aventis is the world's third largest pharmaceutical company, ranking number one in Europe. Backed by a world-class R&D organization, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine, and vaccines. Sanofi-aventis is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expect," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

###

Press Release

Exhibit AA

**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549**

FORM 20-F

(Mark One)

☐ REGISTRATION STATEMENT PURSUANT TO SECTION 12(b) OR (g) OF THE SECURITIES EXCHANGE ACT OF 1934
OR

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2006

OR

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
OR

☐ SHELL COMPANY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
Date of event requiring this shell company report
For the transition period from to

Commission File Number: 001-31368

Sanofi-Aventis

(Exact name of registrant as specified in its charter)

N/A

(Translation of registrant's name into English)

France

(Jurisdiction of incorporation or organization)

174, avenue de France, 75013 Paris, France

(Address of principal executive offices)

Securities registered or to be registered pursuant to Section 12(b) of the Act:

Title of each class:	Name of each exchange on which registered:
American Depositary Shares, each representing one half of one ordinary share, par value €2 per share	New York Stock Exchange
Ordinary shares, par value €2 per share	New York Stock Exchange (for listing purposes only)

Securities registered pursuant to Section 12(g) of the Act:

American Depositary Shares, each representing one quarter of a Participating Share Series A, par value €70.89 per share (removed from listing and registration on the New York Stock Exchange effective July 31, 1995).

The number of outstanding shares of each of the issuer's classes of capital or
common stock as of December 31, 2006 was:

ordinary shares: 1,359,434,683

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405
of the Securities Act.

YES ☒ NO ☐

If this report is an annual or transition report, indicate by check mark if the registrant is not
required to file reports pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934.

YES ☐ NO ☒

Note — Checking the box above will not relieve any registrant required to file reports pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 from their obligations under those Sections.

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒

Accelerated filer ☐

Non-accelerated filer ☐

Indicate by check mark which financial statement item the registrant has elected to follow.

Item 17 ☐ Item 18 ☒

If this is an annual report, indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

YES ☐ NO ☒

PRESENTATION OF FINANCIAL AND OTHER INFORMATION

The consolidated financial statements contained in this annual report on Form 20-F have been prepared in accordance with International Financial Reporting Standards (IFRS) adopted by the European Union as of December 31, 2006 and with IFRS issued by the International Accounting Standards Board (IASB) as of the same date. IFRS differ in certain significant respects from U.S. generally accepted accounting principles (U.S. GAAP). For a description of the principal differences between IFRS and U.S. GAAP, as they relate to us and to our consolidated subsidiaries, and for a reconciliation of our shareholders' equity and net income to U.S. GAAP, see Note F to our consolidated financial statements included at Item 18, of this annual report.

Our results of operations and financial condition as of and for the year ended December 31, 2004 have been significantly affected by our August 2004 acquisition of Aventis and certain subsequent transactions (including the merger of Aventis with and into our Company in December 2004). The results of operations of Aventis for the period between August 20, 2004 and December 31, 2004 have been included in our consolidated income statement and cash flow statement. This resulted in a significant increase in revenues and significant changes in other financial statement items in 2004 compared to 2003. The assets and liabilities of Aventis are also included in our consolidated balance sheet at December 31, 2004. See "Item 5. Operating and Financial Review and Prospects."

We have prepared unaudited pro forma income statements for 2004 that present our results of operations as if the acquisition had taken place on January 1, 2004, described under "Item 5. Operating and Financial Review and Prospects." Because of the significance of the Aventis acquisition, we present certain 2004 financial information in this annual report, such as sales of particular pharmaceutical products, as a percentage of our unaudited pro forma sales, rather than as a percentage of our consolidated sales.

Unless the context requires otherwise, the terms "sanofi-aventis," the "Company," the "Group," "we," "our" or "us" refer to sanofi-aventis and our consolidated subsidiaries. References to "Aventis" refer to Aventis and its consolidated subsidiaries for periods prior to August 20, 2004.

All references herein to "United States" or "U.S." are to the United States of America, references to "dollars" or "\$" are to the currency of the United States, references to "France" are to the Republic of France, and references to "euro" and "€" are to the currency of the European Union member states (including France) participating in the European Monetary Union.

Brand names appearing in this annual report are trademarks of sanofi-aventis and/or its affiliates, with the exception of:

- trademarks used or that may be or have been used under license by sanofi-aventis and /or its affiliates, such as Actonel®, Optinate® and Acrel®, trademarks of Procter & Gamble Pharmaceuticals, Alvesco®, a trademark of ALTANA Pharma AG, Campto®, a trademark of Kabushiki Kaisha Yakult Honsha, Copaxone®, a trademark of Teva Pharmaceutical Industries, Exubera®, a trademark of Pfizer Products Inc., Tavanic®, a trademark of Daiichi Pharmaceutical Co. Ltd., TroVax®, a trademark of Oxford BioMedica, Mutagrip®, a trademark of Institut Pasteur, Gardasil® and Rotateq®, trademarks of Merck & Co., Inc., NanoCrystal®, a trademark of Elan Pharmaceuticals, Uvidem®, a trademark of IDM Pharma, Inc. (IDM), Xyzal®, a trademark of UCB;
- trademarks sold by sanofi-aventis and/or its affiliates, such as Altace®, a trademark of King Pharmaceuticals in the United States, Arixta® and Fraxiparine®, trademarks of GlaxoSmithKline, StarLink®, Liberty Link® and Liberty® trademarks of Bayer AG, Sabril®, a trademark of Ovation Pharmaceuticals in the United States;
- Cipro® in the United States and Aspirin®, trademarks of Bayer AG, Ivomec®, Eprinex®, Frontline® and Heartgard®, trademarks of Merial and Hexavac®, a trademark of Sanofi Pasteur MSD.

The data relative to market shares and ranking information presented in "Item 4. Information on the Company — B. Business Overview — Markets — Competition" is based on sales data from IMS Health MIDAS (IMS) and GERS (for France), retail and hospital, for calendar year 2006, in constant euros (unless otherwise indicated).

While we believe that the IMS/GERS sales data we present below are generally useful comparative indicators for our industry, they may not precisely match the sales figures published by the companies that sell the products (including our company and other pharmaceutical companies). In particular, the rules used by IMS to attribute the sales of a product covered by an alliance or license agreement do not always exactly match the rules of the agreement.

In order to allow a reconciliation with our basis of consolidation as defined in "Item 5. Operating and Financial Review and Prospects — Presentation of Net Sales," IMS data shown in the present document have been adjusted and include:

- (i) sales as published by IMS excluding sales generated by the vaccines business, equating to the scope of our pharmaceutical operations;

- (ii) adjustments to data for Germany, to reflect the significant impact of parallel imports;
- (iii) IMS sales of products sold under alliance or license agreements which we recognize in our consolidated net sales but which are not attributed to us in the reports published by IMS;
- (iv) adjustments related to the exclusion of IMS sales for products which we do not recognize in our consolidated net sales but which are attributed to us by IMS.

Product indications described in this report are composite summaries of the major indications approved in the product's principal markets. Not all indications are necessarily available in each of the markets in which the products are approved. The summaries presented herein for the purpose of financial reporting do not substitute for careful consideration of the full labeling approved in each market.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report contains forward-looking statements. We may also make written or oral forward-looking statements in our periodic reports to the Securities and Exchange Commission on Form 6-K, in our annual report to shareholders, in our proxy statements, in our offering circulars and prospectuses, in press releases and other written materials and in oral statements made by our officers, directors or employees to third parties. Examples of such forward-looking statements include:

- projections of operating revenues, net income, adjusted net income, earnings per share, adjusted earnings per share, capital expenditures, positive or negative synergies, dividends, capital structure or other financial items or ratios;
- statements of our plans, objectives or goals, including those relating to products, clinical trials, regulatory approvals and competition;
- statements about our future economic performance or that of France, the United States or any other countries in which we operate; and
- statements of assumptions underlying such statements.

Words such as "believe," "anticipate," "plan," "expect," "intend," "target," "estimate," "project," "predict," "forecast," "guideline," "should" and similar expressions are intended to identify forward-looking statements but are not the exclusive means of identifying such statements.

Forward-looking statements involve inherent risks and uncertainties. We caution you that a number of important factors could cause actual results to differ materially from those contained in any forward-looking statements. Such factors, some of which are discussed under "Risk Factors" below, include but are not limited to:

- our ability to continue to maintain and expand our presence profitably in the United States;
- the success of our research and development programs;
- our ability to protect our intellectual property rights;
- the risks associated with reimbursement of healthcare costs and pricing reforms, particularly in the United States and Europe; and
- trends in the exchange rate and interest rate environments.

We caution you that the foregoing list of factors is not exclusive and that other risks and uncertainties may cause actual results to differ materially from those in forward-looking statements.

Forward-looking statements speak only as of the date they are made. Other than required by law, we do not undertake any obligation to update them in light of new information or future developments.

TABLE OF CONTENTS

Part I

Item 1.	Identity of Directors, Senior Management and Advisers	1
Item 2.	Offer Statistics and Expected Timetable	1
Item 3.	Key Information	1
	A. Selected Financial Data	1
	B. Capitalization and Indebtedness	3
	C. Reasons for Offer and Use of Proceeds	3
	D. Risk Factors	3
Item 4.	Information on the Company	13
	A. History and Development of the Company	14
	B. Business Overview	15
	C. Organizational Structure	65
	D. Property, Plant and Equipment	66
Item 4A.	Unresolved Staff Comments	67
Item 5.	Operating and Financial Review and Prospects	68
Item 6.	Directors, Senior Management and Employees	110
	A. Directors and Senior Management	110
	B. Compensation	123
	C. Board Practices	126
	D. Employees and profit sharing	128
	E. Share ownership	130
Item 7.	Major Shareholders and Related Party Transactions	132
	A. Major Shareholders	132
	B. Related Party Transactions	133
	C. Interests of Experts and Counsel	133
Item 8.	Financial Information	134
	A. Consolidated Financial Statements and Other Financial Information	134
	B. Significant Changes	135
Item 9.	The Offer and Listing	136
	A. Offer and Listing Details	136
	B. Plan of Distribution	137
	C. Markets	137
	D. Selling Shareholders	139
	E. Dilution	139
	F. Expenses of the Issue	139
Item 10.	Additional Information	140
	A. Share Capital	140
	B. Memorandum and Articles of Association	140
	C. Material Contracts	154
	D. Exchange Controls	154
	E. Taxation	154
	F. Dividends and Paying Agents	159
	G. Statement by Experts	159
	H. Documents on Display	159
	I. Subsidiary Information	160
Item 11.	Quantitative and Qualitative Disclosures about Market Risk	160
Item 12.	Description of Securities other than Equity Securities	163

Part II

Item 13.	Defaults, Dividend Arrearages and Delinquencies	164
Item 14.	Material Modifications to the Rights of Security Holders	164
Item 15.	Controls and Procedures	164
Item 16.	[Reserved]	165
Item 16A.	Audit Committee Financial Expert	165
Item 16B.	Financial Code of Ethics	165
Item 16C.	Principal Accountants' Fees and Services	165
Item 16D.	Exemptions from the Listing Standards for Audit Committees	166
Item 16E.	Purchases of Equity Securities by the Issuer and Affiliated Purchasers	166

Part III

Item 17.	Financial Statements	167
Item 18.	Financial Statements	167
Item 19.	Exhibits	167

PART I

Item 1. Identity of Directors, Senior Management and Advisers

N/A

Item 2. Offer Statistics and Expected Timetable

N/A

Item 3. Key Information

A. Selected Financial Data

SUMMARY SELECTED FINANCIAL DATA

The tables below set forth selected consolidated financial data for sanofi-aventis. These financial data are derived from the sanofi-aventis consolidated financial statements. Sanofi-aventis financial statements for the years ended December 31, 2006, 2005 and 2004 are included in Item 18 of this annual report.

The consolidated financial statements of sanofi-aventis for the years ended December 31, 2006 and 2005 have been prepared in compliance with IFRS adopted by the European Union and with the IFRS issued by the International Accounting Standards Board (IASB). The term “IFRS” refers collectively to International Accounting Standards (IAS), International Financial Reporting Standards (IFRS), Standing Interpretations Committee (SIC) interpretations and International Financial Reporting Interpretations Committee (IFRIC) Interpretations issued by the IASB. The opening balance sheet as of the IFRS transition date (January 1, 2004) and the comparative financial statements for the year ended December 31, 2004 have been prepared in accordance with the same principles.

Sanofi-aventis reports its financial results in euro and in conformity with IFRS, with a reconciliation to U.S. GAAP. Sanofi-aventis also publishes condensed U.S. GAAP information. A description of the principal differences between IFRS and U.S. GAAP as they relate to the sanofi-aventis consolidated financial statements is set forth in Note F to the sanofi-aventis audited consolidated financial statements included in this annual report.

SELECTED CONDENSED FINANCIAL INFORMATION

(€ million, except per share data)	As of and for the year ended December 31,				
	2006	2005	2004	2003	2002
IFRS Income statement data					
Net sales	28,373	27,311	14,871	—	—
Gross profit	21,902	20,947	11,294	—	—
Operating income	4,828	2,888	2,426	—	—
Net income attributable to equity holders of the Company	4,006	2,258	1,986	—	—
Earnings per share: basic (€) (a)	2.97	1.69	2.18	—	—
Earnings per share: diluted (€) (b)	2.95	1.68	2.17	—	—
IFRS Balance sheet data (c)					
Intangible assets and goodwill	52,210	60,463	61,567	—	—
Total assets	77,763	86,945	85,557	—	—
Outstanding share capital	2,701	2,686	2,668	—	—
Equity attributable to equity holders of the Company	45,600	46,128	40,810	—	—
Long term debt	4,499	4,750	8,654	—	—
U.S. GAAP Data (d)					
Revenues from sale of products	28,373	27,311	14,871	8,048	7,448
Net income (loss) attributable to equity holders of the Company	4,034	2,202	(3,665)	1,865	1,640
Earnings (loss) per share: basic (€) (e)	3.00	1.65	(4.03)	2.71	2.30
Earnings (loss) per share: diluted (€) (f)	2.97	1.64	(4.03)	2.70	2.28
Intangible assets and goodwill	52,251	60,451	61,056	9,321	9,924
Total assets	77,536	86,241	82,846	17,424	17,362
Long-term debt	4,483	4,734	8,638	53	65
Equity attributable to equity holders of the Company	46,023	46,403	41,632	12,736	12,599
Cash dividend paid per share (€) (g)	1.75 (h)	1.52	1.20	1.02	0.84
Cash dividend paid per share (\$) (g)	2.31 (h)	1.80	1.62	1.28	0.88

- (a) Based on the weighted average number of shares outstanding in each period used to compute basic earnings per share, equal to 1,346.8 million shares in 2006, 1,336.5 million shares in 2005, and 910.3 million shares in 2004.
- (b) Based on the weighted average number of shares outstanding in each period used to compute diluted earnings per share, equal to 1,358.8 million shares in 2006, 1,346.5 million shares in 2005, and 914.8 million shares in 2004.
- (c) On January 1, 2006, sanofi-aventis adopted (with retrospective effect from January 1, 2004) the option offered by amendment to IAS 19 (Employee Benefits) to recognize all actuarial gains and losses under defined-benefit pension plans in the balance sheet, with the matching entry recorded as a component of shareholder's equity, net of deferred taxes. See Note A.4 of the consolidated financial statements in Item 18 of this annual report.
- (d) Sanofi-aventis voluntarily adopted the fair value recognition provisions of Financial Accounting Standard 123, Accounting for Stock-Based Compensation, as of January 1, 2003.
Certain data as of and for the year ended December 31, 2004 have been reclassified to conform to the presentation adopted under IFRS with respect to joint ventures that are no longer accounted for under the proportionate consolidation method.
- (e) Based on the weighted average number of shares outstanding in each period used to compute basic earnings (loss) per share, equal to 1,346.8 million shares in 2006, 1,336.5 million shares in 2005, 910.3 million shares in 2004, 689.0 million shares in 2003, and 714.3 million shares in 2002.
- (f) Based on the weighted average number of shares outstanding in each period used to compute diluted earnings (loss) per share, equal to 1,357.6 million shares in 2006, 1,346.5 million shares in 2005, 914.9 million shares in 2004, 691.1 million shares in 2003, and 718.0 million shares in 2002.
- (g) Each American Depositary Share, or ADS, represents one half of one share.
- (h) Dividends for 2006 will be proposed to the annual general meeting for approval.

EXCHANGE RATE INFORMATION***Exchange Rates***

The following table sets forth, for the periods and dates indicated, certain information concerning the exchange rates for the euro from 2002 through March 2007 expressed in U.S. dollar per euro. The information concerning the U.S. dollar exchange rate is based on the noon buying rate in New York City for cable transfers in foreign currencies as certified for customs purposes by the Federal Reserve Bank of New York (the "Noon Buying Rate"). We provide the exchange rates below solely for your convenience. We do not represent that euros were, could have been, or could be, converted into U.S. dollars at these rates or at any other rate. For information regarding the effect of currency fluctuations on our results of operations, see "Item 5. Operating and Financial Review and Prospects."

Selected Exchange Rate Information

	Period- end Rate	Average Rate ⁽¹⁾	High	Low
	(U.S. dollar per euro)			
2002	1.05	0.95	1.05	0.86
2003	1.26	1.14	1.26	1.04
2004	1.35	1.25	1.36	1.18
2005	1.18	1.24	1.35	1.17
2006	1.32	1.27	1.33	1.19
Last 6 months				
2006				
October	1.28	1.26	1.28	1.25
November	1.33	1.29	1.33	1.27
December	1.32	1.32	1.33	1.31
2007				
January	1.30	1.30	1.33	1.29
February	1.32	1.31	1.32	1.29
March	1.34	1.32	1.34	1.31

⁽¹⁾ The average of the Noon Buying Rates on the last business day of each month during the relevant period for year average, on each business day of the month for monthly average.

On March 30, 2007 the Noon Buying Rate was 1.3374 per euro.

B. Capitalization and Indebtedness

N/A

C. Reasons for Offer and Use of Proceeds

N/A

D. Risk Factors

Important factors that could cause actual financial or operating results to differ materially from expectations are disclosed in this annual report, including without limitation the following risk factors and the factors described under "Cautionary Statement Regarding Forward-Looking Statements." In addition to the risks listed below, we may be subject to other material risks that are not currently known to us or that we deem immaterial at this time.

Risks Relating to Our Company

We incurred substantial debt in connection with the acquisition of Aventis, which limits our business flexibility and requires us to devote cash resources to debt service payments.

In connection with our acquisition of Aventis, our consolidated debt increased substantially, because we incurred debt to finance the cash portion of the acquisition consideration, and because our consolidated debt includes the debt incurred by Aventis prior to the acquisition. As of December 31, 2006, our debt, net of cash and cash equivalents was €5.8 billion. We make significant debt service payments to our lenders and our current debt level could limit our ability to engage in additional transactions or incur additional indebtedness. For more information on our debt, see “Item 5. Operating and Financial Review and Prospectus — Liquidity and Capital Resources” in this annual report.

We depend on the United States market for a significant part of our current and future operating results. A failure to continue our strategy of profitable operations in that market could adversely affect our business, results of operations, financial condition or prospects.

We may not achieve our growth strategy if we do not maintain and continue to expand profitably our presence in the United States, the world’s largest pharmaceuticals market. We have identified the United States, which accounted for approximately 35.1% of our net sales in 2006, as a potential major source of continued future growth and plan to capitalize on our direct presence in the United States in the coming years to build a strong position in this market. We face a number of challenges in maintaining profitable growth in the United States, including.

- the success of the management organization that we have established in the United States;
- the targeting of new products and customer markets;
- the fact that the United States market is dominated by major U.S. pharmaceutical companies;
- slower growth of the U.S. pharmaceutical market than in recent years;
- aggressive generic competition reinforced by legislative initiatives to further facilitate the introduction of generic drug or comparable biologic products through accelerated approval procedures;
- potential changes in health care reimbursement policies and possible cost control regulations in the United States, including possible unfavorable developments in coverage of prescription drugs by Medicare;
- increased FDA demands, leading to a potentially longer, more costly and more restrictive approval process for innovative products;
- heightened scrutiny of the pharmaceutical industry by the public and the media; and
- exposure to the euro-dollar exchange rate.

We depend on third parties for the marketing of some of our products. These third parties may act in ways that could harm our business.

We market some of our products in collaboration with other pharmaceutical companies. For example, we currently have major collaborative arrangements with Bristol-Myers Squibb (BMS) for the marketing of Plavix® and Aproveil® in the United States and several other countries, with Procter & Gamble Pharmaceuticals for the osteoporosis treatment Actonel®, with Teva for Copaxone®, and with Merck & Co., Inc. for the distribution of vaccines in Europe. We also have alliances with several Japanese companies for the marketing of some of our products in Japan. See “Item 4. Information on the Company — B. Business Overview — Markets — Marketing and Distribution.” When we market our products through collaboration arrangements, we are subject to the risk that certain decisions, such as the establishment of budgets and promotion strategies, are subject to the control of our collaboration partners, and that deadlocks may adversely affect the activities conducted through the collaboration arrangements. For example, our alliances with BMS are subject to the operational management of BMS in some countries, including the United States. We cannot be certain that our partners will perform their obligations as expected. Further, our partners might pursue their own existing or alternative technologies or product candidates in preference to those being developed or marketed in collaboration with us.

The manufacture of our products is technically complex, and supply interruptions, product recalls or inventory losses caused by unforeseen events may reduce sales, delay the launch of new products and adversely affect our operating results and financial condition.

Many of our products are manufactured using technically complex processes requiring specialized facilities, highly specific raw materials and other production constraints. Our vaccine products in particular are subject to the risk of manufacturing stoppages or the risk of loss of inventory because of the difficulties inherent to the sterile processing of biological materials and the potential for the unavailability of adequate amounts of raw materials meeting our standards. Additionally, specific conditions must be respected both by the Group and its customers for the storage and distribution of many of our products, e.g., cold storage for certain vaccines. The complexity of these processes as well as strict company and government standards for the manufacture of our products subject us to risks. The occurrence or suspected occurrence of out-of-specification production or storage can lead to lost inventories, and in some cases product recalls, with consequential reputational damage and the risk of product liability (See “— Risks Relating to Our Industry — Product liability claims could adversely affect our business, results of operations and financial condition,” below). The investigation and remediation of any identified problems can cause production delays, substantial expense, lost sales and the delay of new product launches.

We depend on third parties for the manufacture and supply of a substantial portion of our raw materials, specialized components, active ingredients and medical devices.

Availability of Raw Materials and Specialized Components. Third parties supply us with a substantial portion of our raw materials and specialized components. Some raw materials and specialized components essential to the manufacture of our products are not widely available from sources we consider reliable — for example, there is a limited number of approved suppliers of heparins, which are used in the manufacture of Lovenox®. See “Item 4. Information on the Company — B. Business Overview — Production and Raw Materials” for a description of these outsourcing arrangements.

Third-Party Manufacturing of Active Ingredients. Although our general policy is to manufacture the active ingredients for our products ourselves, we subcontract the manufacture of some of our active ingredients to third parties, which exposes us to the risk of a supply interruption in the event that our suppliers experience financial difficulties or are unable to manufacture a sufficient supply of our products. The manufacture of the active ingredients for Eloxatine® and Xatral® and part of the manufacture of the active ingredient for Stilnox® are currently carried out by third parties, as are some of the manufacturing steps in the production of Lovenox®. Additionally, under our collaborative arrangement with BMS, pharmaceutical production of Plavix® and Aprove1® is conducted partly in sanofi-aventis plants and partly in BMS plants.

Third-Party Supply of Medical Devices. Medical devices related to some of our products, such as certain pens used to dispense insulin, are manufactured by third parties. Reliance on third parties exposes us to the risk of supply interruptions, including as a result of third-party manufacturing problems, as well as the risk of product liability for materials not produced by the Group. See “— Product liability claims could adversely affect our business, results of operations and financial condition,” below.

If disruptions or quality concerns were to arise in the third-party supply of raw materials, specialized components, active ingredients or medical devices, this could affect our ability to sell our products in the quantities demanded by the market and could damage our reputation and relationships with our customers. See also “— The manufacture of our products is technically complex, and supply interruptions, product recalls or inventory losses caused by unforeseen events may reduce sales, delay the launch of new products and adversely affect our operating results and financial condition,” above. Even though we aim to have backup sources of supply whenever possible, including by manufacturing backup supplies of our principal active ingredients at a second or third facility when practicable, we cannot be certain they will be sufficient if our principal sources become unavailable. Any of these factors could adversely affect our business, operating results or financial condition.

Our collaborations with third parties expose us to risks that they will claim intellectual property rights on our inventions or fail to keep our unpatented technology confidential.

We occasionally provide information and materials to research collaborators in academic institutions or other public or private entities, or request them to conduct tests to investigate certain materials. In all cases we enter into appropriate confidentiality and intellectual property rights agreements with such entities. However,

those entities might claim intellectual property rights with respect to the results of the tests conducted by their collaborators, and might not grant licenses to us regarding their intellectual property rights on acceptable terms.

We also rely upon unpatented proprietary technology, processes, know-how and data that we regard as trade secrets and protect them in part by entering into confidentiality agreements with our employees, consultants and certain contractors. We cannot be sure that these agreements or other trade secret protections will provide meaningful protection, or, if they are breached, that we will have adequate remedies. You should read “Item 4. Information on the Company — B. Business Overview — Patents, Intellectual Property and Other Rights” for more information about our patents and licenses.

Claims and investigations relating to marketing practices and competition law could adversely affect our business, results of operations and financial condition.

The marketing of our products is heavily regulated, and alleged failures to comply fully with applicable regulations could result in civil or criminal actions against us, and in some circumstances potential disqualification from participation in government health programs. Sanofi-aventis and certain of its subsidiaries are under investigation by various federal government entities in the United States, and are defendants in a number of lawsuits, relating to antitrust and/or pricing and marketing practices, including, for example, class action lawsuits and qui tam litigation. See Note D.22.c) to our consolidated financial statements included at Item 18 of this annual report.

Following judgments holding the U.S. patent protection of Lovenox® and of DDAVP® tablets to be unenforceable, a number of civil antitrust and fair trade claims have been filed against sanofi-aventis as putative class actions alleging that the Group has prevented competition and generated excess profits. Similar claims have followed an attempt to settle our U.S. Plavix® patent litigation. The proposed settlement of the U.S. Plavix® patent litigation against Apotex by the parties thereto is also the subject of a criminal investigation by the Antitrust Division of the U.S. Department of Justice, of which the outcome and impact on sanofi-aventis cannot reasonably be assessed at this time. See “Item 8. Financial Information — A. Consolidated Financial Statements and other Financial Information — Information on Legal or Arbitration Proceedings” and Note D.22 c) to our consolidated financial statements included at Item 18 of this annual report.

Because many of these cases allege substantial unquantified damages, may be subject to treble damages, and frequently seek significant punitive damages and penalties, it is possible that any final determination of liability or settlement of these claims or investigations could have a material adverse effect on our business, results of operations or financial condition.

Fluctuations in currency exchange rates could adversely affect our results of operations and financial condition.

Because we sell our products in numerous countries, our results of operations and financial condition could be adversely affected by fluctuations in currency exchange rates. We are particularly sensitive to movements in exchange rates between the euro and the U.S. dollar, the British pound, the Japanese yen, and to a lesser extent to currencies in emerging countries. In 2006, approximately 35.1% of our net sales were realized in the United States. While we incur expenses in those currencies, the impact of currency exchange rates on these expenses does not fully offset the impact of currency exchange rates on our revenues. As a result, currency exchange rate movements can have a considerable impact on our earnings. When deemed appropriate, we enter into transactions to hedge our exposure to foreign exchange risks. These efforts, when undertaken, may fail to offset the effect of adverse currency exchange rate fluctuations on our results of operations or financial condition. For more information concerning our exchange rate exposure, see “Item 11. Quantitative and Qualitative Disclosures About Market Risk.”

Risks Relating to Our Industry

We must invest substantial sums in research and development in order to remain competitive, and we may not fully recover these investments if our products are unsuccessful in clinical trials or fail to receive and maintain regulatory approval.

To be successful in the highly competitive pharmaceutical industry, we must commit substantial resources each year to research and development in order to develop new products. In 2006, we spent €4,430 million on

research and development, amounting to approximately 15.6 % of our net sales. Our ongoing investments in new product launches and research and development for future products could result in higher costs without a proportionate increase in revenues.

The research and development process is lengthy and carries a substantial risk of product failure. If our research and development does not yield sufficient new products that achieve commercial success, our future operating results may be adversely affected.

The research and development process typically takes from 10 to 15 years from discovery to commercial product launch. This process is conducted in various stages, and during each stage there is a substantial risk that we will not achieve our goals and will have to abandon a product in which we have invested substantial amounts.

For example, in order to develop a commercially viable product, we must demonstrate, through extensive pre-clinical and human clinical trials, that the pharmacological compounds have an acceptable benefit/risk profile for human use in the proposed indications. There is also no assurance that favorable results obtained in pre-clinical trials will be confirmed by later clinical trials, or that the clinical trials will establish safety and efficacy data sufficient for regulatory approval. In the first quarter of 2007, we had 125 compounds in pre-clinical and clinical development in our targeted therapeutic areas, of which 58 were in Phase II or Phase III clinical trials. For additional information regarding clinical trials and the definition of the phases of clinical trials, see “Item 4. Information on the Company — B. Business Overview — Research & Development.” There can be no assurance that any of these compounds will be proven safe or effective, or that they will produce commercially successful products.

After completing the research and development process, we must invest substantial additional resources with a view to obtaining government approval in multiple jurisdictions, with no assurance that approval will be obtained. We must obtain and maintain regulatory approval for our pharmaceutical products from the European Union, the United States and other regulatory authorities before a given product may be sold in these markets. The submission of an application to a regulatory authority provides no assurance that the regulatory authority will grant a license to market the product. Each authority may impose its own requirements, including requiring local clinical studies, and may delay or refuse to grant approval, even though a product has already been approved in another country.

In our principal markets, the approval process for one or more indications of a new product is complex and lengthy, and typically takes from six months to two years from the date of application depending on the country. Moreover, if regulatory approval of a product is granted, the approval may place limitations on the indicated uses for which it may be marketed. A marketed product is also subject to continual review even after regulatory approval. Later discovery of previously unknown problems may result in marketing restrictions or withdrawal of the product, as well as an increased risk of litigation. See also “— Product liability claims could adversely affect our business, results of operations and financial condition,” below. In addition, we are subject to strict government controls on the manufacture, labeling, distribution and marketing of our products. Each of these factors may increase our costs of developing new products and the risk that we may not succeed in selling them successfully.

Obtaining regulatory marketing approval is not a guarantee that the product will achieve commercial success. Commercial success is dependent on a number of factors beyond our control, notably the level of reimbursement which is accorded to the product by public health entities and third-party payers in each country, the acceptance of the product by the medical establishment and patients, and the existence and price of competing products and alternative therapies.

If we are unable to protect our proprietary rights, we may fail to compete effectively or operate profitably.

It is important for our success that we be able to effectively obtain and enforce our patents and other proprietary rights. We hold a broad portfolio of patents, patent licenses and patent applications worldwide. To the extent effective patent protection of our products is not maintained, these products will become exposed to competition from generic products. The entry of a generic product into the market typically is followed by a substantial decline in the brand-name product’s sales volume and revenues.

Obtaining Patent Rights. Patent law relating to the scope of claims in the pharmaceutical field in which we operate is continually evolving and can be the subject of some uncertainty. Accordingly, we cannot be sure that:

- new, additional inventions will be patentable;
- patents for which applications are now pending will be issued or reissued to us; or
- the scope of any patent protection will be sufficiently broad to exclude competitors.

Patent protection once obtained is limited in time (typically 20 years), after which competitors may use the covered technology without obtaining a license from us. Because of the time required to obtain regulatory marketing approval, the period of effective patent protection for a marketed product is frequently substantially shorter.

Enforcing Patent Rights. Our competitors may infringe our patents or successfully avoid them through design innovation. To prevent infringement, we may file infringement claims, which are expensive and time consuming and which may result in decisions unfavorable to us. Policing unauthorized use of our intellectual property is difficult, and we may not be able to prevent misappropriation of our proprietary rights. We may also be accused of infringing the rights of others who then seek substantial damages from us. This risk is increased by the growth in the number of patent applications filed and patents granted in the pharmaceutical industry.

Even prior to the scheduled expiration of a patent, third parties may challenge the validity of the patents issued or licensed to us, which may result in the invalidation of these rights and the loss of sales derived from the related products. Such challenges have become increasingly common in recent years. Typical assertions in suits challenging a patent are that (i) the competing product does not fall within the scope of the patent, (ii) that the patent claims matters that are not in fact patentable, for example because they are not a true innovation; or (iii) that there were procedural flaws that invalidate the patent office's decision to issue the patent. Patent litigation is subject to substantial uncertainty, and we cannot be sure how much protection, if any, will be provided by our patents if we attempt to enforce them and they are challenged in court or in other proceedings.

Additionally, if a competitor chooses to take the risk of launching an infringing product prior to a court's determination that our patent rights are valid, enforceable and infringed, there can be no assurance that we will (i) be successful in obtaining a preliminary injunction to halt further sales and remove the infringing product from the market prior to obtaining a final injunction at trial, and even if we are successful, (ii) be able to obtain an award of sufficient damages from the competitor to repair all harm caused to us and (iii) effectively collect this award. By way of example, following the Group's failure to obtain a preliminary injunction halting the launch at risk of a generic version of Allegra® in October 2005, the Allegra® franchise in the United States has been substantially eroded and the asserted patent claims have still not gone to trial. While we were successful in obtaining a preliminary injunction halting further sales of a generic Plavix® in August 2006, the significant quantities of generic product already distributed prior to the injunction have had a significant negative effect on 2006 earnings and caused us substantial and persistent commercial harm.

Our patent rights are material to our business, and if we were unsuccessful in asserting them or they were deemed invalid, any resulting introduction of generic versions of our products in the United States, in Europe or in other markets would reduce the price that we receive for these products and the volume of the product that we would be able to sell, and could materially adversely affect our business, results of operations and financial condition. Additionally, a number of our products acquired through business combinations have substantial balance sheet carrying values, as disclosed at Note D.4 to our consolidated financial statements, which could be substantially impaired by the introduction of a generic competitor, with adverse effects on our financial results and assets.

Significant challenges to our proprietary rights concern such leading Group products as Plavix®, Lovenox®, Eloxatine® and Allegra®. We are also involved in litigation challenging the validity or enforceability of patents related to a number of other products in the United States, the European Union and elsewhere, and challenges to other products may be expected in the future. We can give no assurance that as a result of these challenges we will not face generic competition for additional group products. See "Item 8. Financial Information — A. Consolidated Financial Statements and Other Financial Information — Information on Legal or Arbitration Proceedings" and Note D.22.b) to our consolidated financial statements included in this annual report at Item 18 for additional information.

Product liability claims could adversely affect our business, results of operations and financial condition.

Product liability is a significant commercial risk for us, and has become a more significant risk as we expand in the United States (where product liability claims can be particularly costly). Substantial damage awards have been made in certain jurisdictions against pharmaceutical companies based upon claims for injuries allegedly caused by the use of their products. Not all possible side effects of a drug can be anticipated based on preapproval clinical studies involving only several hundred to several thousand patients. Routine review and analysis of the continually growing body of post-marketing safety surveillance and clinical trials provide additional information — for example potential evidence of rare, population-specific or long-term adverse reactions or of drug interactions that were not observed in preapproval clinical studies — and may cause product labeling to evolve. Several pharmaceutical companies have recently recalled or withdrawn products from the market based on actual or suspected adverse reactions to their products, and currently face significant product liability claims. We are currently defending a number of product liability claims (see Note D.22 to the consolidated financial statements included at Item 18 of this annual report and “Item 8. Financial Information — A. Consolidated Financial Statements and Other Financial Information — Information on Legal or Arbitration Proceedings”), and there can be no assurance that the Group will not face additional claims in the future. Although we maintain insurance to cover the risk of product liability, available insurance may not be sufficient to cover all potential liabilities. Further, we face a general trend in the insurance industry to reduce product liability coverage, by excluding products or by imposing limits for liabilities, causing companies to rely increasingly on self-insurance. Substantial product liability claims, if successful, could adversely affect our business, results of operations and financial condition.

Counterfeit products could harm the business of sanofi-aventis.

The prescription drug supply has been increasingly challenged by vulnerability of distribution channels to illegal counterfeiting and the presence of counterfeit products in a growing number of markets and over the internet. Counterfeit products are frequently unsafe or ineffective, and can be potentially life-threatening. To distributors and users counterfeits may be visually indistinguishable from the authentic version. Reports of adverse reactions to counterfeit drugs or increased levels of counterfeiting could materially affect patient confidence in the authentic product, and could harm the business of companies such as sanofi-aventis. Additionally, it is possible that adverse events caused by unsafe counterfeit products will mistakenly be attributed to the authentic product, entailing substantial reputational and financial harm to the manufacturer of the authentic product.

Use of biologically derived ingredients may face consumer resistance, which could adversely affect sales and cause us to incur substantial costs.

In line with industry practice, we manufacture our vaccines and many of our prescription pharmaceutical products with ingredients derived from animal or plant tissue. Most of these products cannot be made economically, if at all, with synthetic ingredients. We subject our products incorporating these ingredients to extensive tests and believe them to be safe. There have been instances in the past where the use of biologically derived ingredients by sanofi-aventis or its competitors has been alleged to be an actual or theoretical source of harm, including infection or allergic reaction, or instances where production facilities have been subject to prolonged periods of closure because of possible contamination. Such allegations have on occasion led to damage claims and increased consumer resistance to such ingredients. A substantial claim of harm caused by a product incorporating biologically derived ingredients or a contamination event could lead us to incur potentially substantial costs as a result of, among other things, litigation of claims, product recalls, adoption of additional safety measures, manufacturing delays, investment in consumer education, and development of synthetic substitutes for ingredients of biological origin. Such claims could also generate consumer resistance, with a corresponding adverse effect on sales and results of operations.

We face uncertainties over the pricing of pharmaceutical products.

The commercial success of our products depends in part on the conditions under which our products are reimbursed. Price pressure is strong due to:

- price controls imposed by governments in many countries;

- removal of a number of drugs from government reimbursement schemes;
- increased difficulty in obtaining and maintaining satisfactory drug reimbursement rates; and
- the tendency of governments and private health care providers to favor generic pharmaceuticals.

Price pressure is considerable in our two largest markets, Europe and the United States, which represented approximately 43.1% and 35.1%, respectively, of our net sales in 2006. Pricing in the German market posed significant challenges for the Group in 2006, including a decision to classify Acomplia® as a non-reimbursed quality-of-life drug; substantial restrictions on the reimbursement of fast-acting analog insulin; and the announcement that the government was evaluating restrictions on additional products. Changes in the pricing environments in the United States or European markets could have a significant impact on our sales and results of operations. See “Item 4. Information on the Company — B. Business Overview — Markets — Pricing” for a description of certain regulatory pricing systems that affect our Group.

Our results may also be adversely affected by parallel imports, a practice by which traders exploit price differentials among markets by purchasing in lower-priced markets for resale in higher-priced markets.

Changes in the marketing status or competitive environment of our major products could adversely affect our results of operations.

In some cases, pharmaceutical products face the risk of being switched from prescription drug status to over-the-counter (OTC) drug status by national regulatory authorities. OTC drugs may not benefit from the same reimbursement schemes and are generally priced significantly lower than brand-name prescription drugs. The competitive environment for our products could also be adversely affected if generic or OTC versions of competitors’ products were to become available.

Risks from the handling of hazardous materials could adversely affect our results of operations.

Pharmaceutical manufacturing activities, such as the chemical manufacturing of the active ingredients in our products and the related storage and transportation of raw materials, products and wastes expose us to various risks, including:

- fires and/or explosions from inflammable substances;
- storage tank leaks and ruptures; and
- discharges or releases of toxic or hazardous substances.

These operating risks can cause personal injury, property damage and environmental contamination, and may result in:

- the shutdown of affected facilities; and
- the imposition of civil or criminal penalties.

The occurrence of any of these events may significantly reduce the productivity and profitability of a particular manufacturing facility and adversely affect our operating results.

Although we maintain property, business interruption and casualty insurance that we believe is in accordance with customary industry practices, we cannot assure you that this insurance will be adequate to cover fully all potential hazards incidental to our business. For more detailed information on environmental issues, see “Item 4. Information on the Company — B. Business Overview — Health, Safety and Environment.”

Environmental liabilities and compliance costs may have a significant adverse effect on our results of operations.

The environmental laws of various jurisdictions impose actual and potential obligations on our Group to remediate contaminated sites. These obligations may relate to sites:

- that we currently own or operate;

- that we formerly owned or operated; or
- where waste from our operations was disposed.

These environmental remediation obligations could significantly reduce our operating results. In particular, our accruals for these obligations may be insufficient if the assumptions underlying these accruals prove incorrect or if we are held responsible for additional, currently undiscovered contamination. Sanofi-aventis accrues reserves for remediation when our management believes the need is probable and that it is reasonably possible to estimate the cost. These judgments and estimates may later prove inaccurate, and any shortfalls could have a material adverse effect on our results of operations. See “Item 4. Information on the Company — B. Business Overview — Health, Safety and Environment” for additional information regarding our environmental policies.

Furthermore, we are or may become involved in claims, lawsuits and administrative proceedings relating to environmental matters. Some current and former sanofi-aventis subsidiaries have been named as “potentially responsible parties” or the equivalent under the U.S. Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (also known as “Superfund”), and similar statutes in the United States, France, Germany, Brazil and elsewhere. As a matter of statutory or contractual obligation, we and/or our subsidiaries may retain responsibility for environmental liabilities at some of the sites our predecessor companies, or our subsidiaries that we demerged, divested or may divest. We have disputes outstanding, for example, with Albemarle and Rhodia over environmental remediation at several sites no longer owned by the Group. An adverse outcome in such disputes might have a significant adverse effect on our operating results. See Note D.22.e) to the consolidated financial statements included at Item 18 of this annual report.

Finally, stricter environmental, safety and health laws and enforcement policies could result in substantial costs and liabilities to our Group and could subject our handling, manufacture, use, reuse or disposal of substances or pollutants to more rigorous scrutiny than is currently the case. Consequently, compliance with these laws could result in significant capital expenditures as well as other costs and liabilities, thereby adversely affecting our business, results of operations or financial condition.

Risks Relating to an Investment in our Shares or ADSs

Foreign exchange fluctuations may adversely affect the U.S. dollar value of our ADSs and dividends (if any).

As a holder of ADSs, you may face exchange rate risk. Our ADSs trade in U.S. dollars and our shares trade in euro. The value of the ADSs and our shares could fluctuate as the exchange rates between these currencies fluctuate. If and when we do pay dividends, they would be denominated in euro. Fluctuations in the exchange rate between the euro and the U.S. dollar will affect the U.S. dollar amounts received by owners of ADSs upon conversion by the depositary of cash dividends, if any. Moreover, these fluctuations may affect the U.S. dollar price of the ADSs on the New York Stock Exchange (NYSE), whether or not we pay dividends in addition to the amounts, if any, that you would receive upon our liquidation or upon the sale of assets, merger, tender offer or similar transactions denominated in euro or any foreign currency other than U.S. dollars.

If you hold ADSs rather than shares it may be difficult for you to exercise some of your rights as a shareholder.

As a holder of ADSs, it may be more difficult for you to exercise your rights as a shareholder than it would be if you directly held shares. For example, if we offer new shares and you have the right to subscribe for a portion of them, the depositary is allowed, at its own discretion, to sell for your benefit that right to subscribe for new shares instead of making it available to you. Also, to exercise your voting rights, as a holder of ADSs, you must instruct the depositary how to vote your shares. Because of this extra procedural step involving the depositary, the process for exercising voting rights will take longer for you, as a holder of ADSs, than for holders of shares. ADSs for which the depositary does not receive timely voting instructions will not be voted at any meeting.

Our two largest shareholders own a significant percentage of the share capital and voting rights of sanofi-aventis.

At December 31, 2006, Total and L'Oréal, our two largest shareholders, held approximately 13.1% and 10.5% of our issued share capital, respectively, accounting for approximately 19.3% and approximately 17.3%, respectively, of the voting rights (excluding treasury shares) of sanofi-aventis. See "Item 7. Major Shareholders and Related Party Transactions — A. Major Shareholders."

To the extent these shareholders continue to hold a large percentage of our share capital and voting rights, Total and L'Oréal will remain in a position to exert heightened influence in the election of the directors and officers of sanofi-aventis and in other corporate actions that require shareholders' approval. Continued ownership of a large percentage of the share capital and voting rights of sanofi-aventis by these two principal shareholders, affiliates of whom may also continue to be members of the sanofi-aventis board of directors, may have the effect of delaying, deferring or preventing a future change in the control of sanofi-aventis and may discourage future bids for sanofi-aventis other than with the support of these shareholders.

Sales of our shares may cause the market price of our shares or ADSs to decline.

Neither Total nor L'Oréal are, to our knowledge, subject to any contractual restrictions on the sale of the shares each holds in our Company. Sales of a substantial number of our shares, or a perception that such sales may occur, could adversely affect the market price for our shares and ADSs.

produce more insulin both at mealtime and between meals and by decreasing insulin resistance. Studies demonstrate that a patient can achieve a very good level of control with a low risk of hypoglycemia.

Amaryl® was first launched in 1995 and has been approved in about 100 countries worldwide. The key markets for Amaryl® are Japan (rank: #1), France (rank: #2) and the United States (rank: #3) (source: IMS/GERS year end 2006 sales).

Acomplia®

Acomplia® (rimonabant) is the first in a new class of therapeutics called selective CB-1 receptor blockers which regulates energy balance and body weight, and improves glucose and lipid metabolism. Rimonabant is indicated in the treatment of obese or overweight patients with associated type 2 diabetes or dyslipidemia risk factors.

Throughout an extensive Phase III clinical trial (RIO program) it has been shown that treatment with Acomplia® results in reduction in weight and waist circumference (a key marker of abdominal obesity), together with improvements on HDL-C, TG and glycemic control in a broad range of patients with multiple cardio-metabolic risk factors. Approximately half of the improvements seen with Acomplia® on HDL-C, TG and HbA1C (a marker of glycemic control) is believed to arise directly from blockade of peripheral CB-1 receptors in metabolically active tissues such as the liver, adipose tissues and skeletal muscles.

To establish rimonabant's efficacy in type 2 diabetes and ultimately demonstrate its role in the prevention of type 2 diabetes and cardiovascular disease, an ambitious life cycle management plan has been set up with 10 Phase IIIb clinical studies. The recent release of SERENADE, a 6-month, randomized, double-blind, placebo-controlled, parallel-group, fixed dose (20 mg once daily) study, further confirms the interest of Acomplia® in improving risk factors of type 2 diabetic patients by demonstrating that rimonabant, as a monotherapy, significantly improved glycemic control in type 2 diabetes patients, with clinically meaningful reductions in HbA1c, associated with robust weight loss, reduced waist circumference and improved lipid profile. The results of SERENADE were submitted to the United States and European regulatory authorities in early 2007.

In Japan, results of a 526-patient Phase IIb study demonstrated an impressive consistency in terms of benefits on weight and cardio-metabolic risk factor reduction as compared to the results of previous European and U.S. studies. Rimonabant demonstrated a good safety profile in this population. In addition, a clear reduction in visceral fat was observed in patients who underwent CT-scan. Phase III studies are currently in progress for two indications: diabetes and weight management. A submission in Japan is planned for 2009.

Acomplia® was been approved in Europe in June 2006 and has already been launched in Germany, the United Kingdom and some other European countries as well as in some countries of Latin America. It has been launched in France in the first quarter of 2007. The New Drug Application (NDA) is being reviewed by the FDA, which has set a user fee goal date of July 26, 2007.

Oncology

Sanofi-aventis is a leading group in the oncology field, primarily in chemotherapy, with two major agents: Taxotere® and Eloxatine®.

Taxotere®

Taxotere® (docetaxel), a drug in the taxoid class of chemotherapeutic agents, inhibits cancer cell division by essentially "freezing" the cell's internal skeleton, which is comprised of microtubules. Microtubules assemble and disassemble during a cell cycle. Taxotere® promotes their assembly and blocks their disassembly, thereby preventing many cancer cells from dividing and resulting in death in some cancer cells.

Taxotere® was first licensed in 1995 in Europe, for use in patients with locally advanced or metastatic breast cancer. The following year, it was granted approval in the United States, Canada and Japan. It is now available in more than 100 countries and, in the 10 years since its launch, Taxotere® has gained approval for use in ten indications in five different tumor types — breast, prostate, gastric, lung and head and neck.

Exhibit BB

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Event Date/Time: Feb. 13. 2007 / 2:30AM ET

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

CORPORATE PARTICIPANTS

Jean-Francois Dehecq

Sanofi-Aventis - Chairman of the Board

Gerard Le Fur

Sanofi-Aventis - CEO

Hanspeter Spek

Sanofi-Aventis - EVP, Pharmaceutical Operations

Wayne Pisano

Sanofi-Aventis - SVP, Corporate Commercial Operations

Jean-Claude Leroy

Sanofi-Aventis - CFO

Pierre Chancel

Sanofi-Aventis - Head of Global Marketing

Marc Cluzel

Sanofi-Aventis - Head of Research and Development

CONFERENCE CALL PARTICIPANTS

Sebastien Berthon

Exane BNP Paribas - Analyst

Graham Parry

Merrill Lynch - Analyst

Philip Brennan

IXIS Securities - Analyst

Ben Yeoh

Dresdner Kleinwort - Analyst

Max Heron

ING - Analyst

Ivan Meu

La Monde - Media

Samuel Cohen

DSM Radio - Media

PRESENTATION

Jean-Francois Dehecq - *Sanofi-Aventis - Chairman of the Board*

[Interpreted]. Ladies and gentlemen good morning. Kindly be seated.

Well, I am pleased to open this information meeting, information on the year 2006. Not an easy year for us and an easy year during which what we referred to as major adverse events in the press releases were not in short supply.

What counts is the ability of the Company to react in the face of these major adverse events is -- was indeed considerable. And in spite of those events, and a number of examples that were cited over the year, the Company has continued to increase its earnings.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

As the team by my side will describe, there's a major change at the beginning of this year, Gerard Le Fur is now CEO of the Company. It won't be any major change for you. I am sure you know everyone here.

For my part, it was, indeed, a very great pleasure to be able to form a team that will take over the management of this Company, people in whom I have every confidence and great esteem.

Well, for my part, what will remain, I will of course remain in the Company as Chairman of the Board. It is my intention to continue to serve this Company passionately and I shall therefore be available to assist my colleagues with whom we have worked for such a long time.

Before handing over to Gerard Le Fur, I'd just like to say a few words to thank those of you who have accompanied us over the years. If I tell you that this is my 27th year of financial analyst meetings, it gives you an idea of the number of meetings that I have taken part in since the Company was formed back in the earlier 70s, when I founded the company in '73 with Rene Sautier.

I'd like to thank those of you who, for some time now, perhaps not as long as I have, have followed the expansion, this adventure. I have to say that we have together really lived quite extraordinary times and it's far from over.

Gerard, over to you. You can come to the rostrum if you want.

Gerard Le Fur - *Sanofi-Aventis - CEO*

[Interpreted]. Thank you, Jean-Francois. Good morning everybody.

You will obviously appreciate that I can't begin this meeting without telling you, like my colleagues beside me, I have had the opportunity to work for a great man for 20 years in every sense. And it was a great source of happiness and we are all delighted, and I should say even more so to say that we still have a few more years to work for and with Jean-Francois.

Having said that, here is the program for this morning. It will be rather long. Hanspeter, as you know, Executive Vice President, Pharmaceutical Operations, will start off, will discuss the Pharmaceutical market.

And then Wayne Pisano, Senior Vice President of Corporate Commercial Operations of Sanofi Pasteur will discuss Vaccines.

And then Jean-Claude Leroy, our CFO, will present the figures and results.

And then it will be over to the new wave, even if you know them well, because it will be a duo between Pierre Chancel, Head of Global Marketing and Marc Cluzel, Head of Research and Development who will give you perhaps a more strategic perspective than previously to demonstrate the extent of cooperation between Marketing and R&D heading the Company in terms of product development.

Without further ado, Hanspeter.

Hanspeter Spek - *Sanofi-Aventis - EVP, Pharmaceutical Operations*

Jean-Francois said that 2006 has been a difficult year. And yes, I can nothing but confirm. If you look to the first of my slides, you see the development of the Pharmaceutical market over the recent years.

And it is evident that this market has changed, at least has changed in terms of growth. This has been a market traditionally a two digits of growth and you see then that as of 2002, but definitely as of 2005. And reconfirmed now in 2006, this market has

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

slimmed down in terms of growth and turned around today 6%. Still a remarkable growth if you compare with other businesses. But nevertheless, on the background of the recent growth, quite a change.

I believe, perhaps even more importantly for our future as an industry, the fact that you can still have growth of 6%, which is about 2 points above the growth of global economy, indicating that there will be continued pressure on prices, on consumption for the pharmaceutical industry. This is probably nothing new.

2006 overall showed diverging trends. And this is specifically true when you look to this picture which shows the development of the various parts of the worldwide market from a geographical angle.

And in the left column you see something which is not really surprising. Yes, evidently the United States still stands for approximately half of the world consumption of pharmaceutical products.

What has really changed is the contribution to growth. And there, if you look to the right, the right bar you will see then that the international section, which means Africa, to a much lesser extent, but definitely South America and especially Asia Pacific has tremendously changed in terms of growth levels, because from both parts of the world in 2006 nearly 30% of growth has come from.

And you see then, that the yes, America lends to a proportional picture of approximately 45% to 47%. And yes, you see that the contribution coming from Europe has shrunk and definitely has shrunk coming from France and Germany. This was one of the major issues we had to address during 2006 because those two markets are our home markets, as you know.

Another angle to portfolios. Yes, it is true that this market has lost in terms of dynamics. But there are still segments, therapeutical segments, portfolio parts which are doing much, much better than average. And you see it here so far those therapies indicated, initiated primarily by specialists. And a leading example, of course, is oncology. We see there was a growth of 21%. But also other fields like diabetes.

Now if you look, it is very simple solution to say yes, we have to reduce our presence in GPs and in the retail segment. It is too simple because if you go to diabetes, and I will give you some results in an instant, you will see that at the same time in very important fields the GP still is increasing its importance because it is more and more, and I say as an example of diabetes, the GP was starting insulin therapy. So yes, it would be easy, but unfortunately it's not possible. We cannot just abandon our presence, our promotional presence with the GPs.

Those four segments, I think it is good to state and pleasant that out of those four segments showing very strong growth, oncology, diabetes and vaccines, we are strongly present in three out of those therapeutical areas.

Now, how did we perform in 2006 in this environment in terms of our sales. First of all, it's obvious the full year finished with a growth of 4%, consisting of 2.5% growth coming from Pharma and a remarkable 23% coming from Vaccines.

Perhaps more importantly, also from a forward-looking perspective, the comeback the Company made in the fourth quarter of 2006 which brought a 6.2% growth for Pharma and a further acceleration of growth up to 30% for Vaccines, which made us finish the fourth quarter with a growth of 8.4%. 8.4% for the total Company.

This comeback has been largely driven by the recovery of our sales, especially in the United States, which is jumping from 3.9% for the full year to 15.6% for the first results of the quarter. And to a lesser extent from international where you see that the growth of international further accelerated to 12.4%.

The strong recovery becomes even more obvious when you analyze our Pharma sales on a quarter-by-quarter basis. So, as the chart shows, we had a very strong two-digit growth until the end of the third quarter 2005, 10.4%.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

And then the first of the major controversial events appeared. Allegra, that surprisingly for us generic competition, we lost the sales of three other products in the United States, all over on annual basis, we lost nearly 2b of sales.

Consequently, sales growth dropped to 1.6% in the fourth quarter. Remained more or less on the same level, even got slightly negative in the third quarter. And then you see the comeback for mainly, not only but mainly just for technical reasons because by the first quarter 2006, this [bust-up] effect is over and we have now have now historical base which is correct.

Equally strong the performance in the fourth quarter for the major products, the leading 15 products, our key products, where you see that sales have been growing by 11% for the fourth quarter, as compared to 6.4% for the full year.

On an annual basis, our eight blockbusters are all growing. Five out of them at two-digit growth. Spectacular, I believe, the growth of Ambien and Lantus of above 30%. And you see then again another technical effect when looking to the figures for Plavix in the fourth quarter, which is not at all a reflection of sluggish market growth, it was just expression of the fact that due to the appearance of the generics in the United States, our deliveries took a [inaudible] [split] and naturally had to be reduced, so it is, again, a technical effect.

Evidently we had to react to those difficulties in 2006. And if you look to the upper right side of the chart, you see that those effect very significantly from one part of the world to the other.

And the overall policy has been to address difficulties on a regional basis and not on a global basis for a simple reason. It would have been foolish to cut on a global basis in those parts of the world where we have significant opportunities.

So what we did, we readjusted our structures in those parts of the world where we face difficulties, mainly in the United States, beginning already at the end of 2005. At the beginning of 2006 we made important changes in France and in Germany, also in terms of headcount. And yes, we also readjusted our structure here at our Paris international headquarters.

You see that internally, and I give you just one example, we readjusted and reallocated our promotional assets. And the example you see on the lower right side of the chart is the United States, where we readjusted in taking away resources from Allegra and Ketek and we put them on top of Ambien and on Lantus. And that you have seen before. It was a good decision because it accelerated the growth of those products even further.

Beyond, we have [reasoned] our business model. We have structured our business launch four axes which are also in the center of our central research and development. You'll hear more about it during the morning. So we structured our portfolio further in order to optimize promotion. We leveraged our geographical opportunities. We shaped the market by our health outcome data. And, finally, we did significant efforts to even improve further our access, especially in the United States, but also in Europe.

What did we achieve? In line with the activities of our research we structured around those four clusters, cardiometabolic, CNS, oncology and, for the first time, through the launch of Gardasil, together with Merck, we obtained synergies between Vaccines and Pharmaceuticals. Those key products benefit still, and I believe they continue to benefit, from cross-promotional efforts hospitals, GPs and specialists.

And in those markets where we see growing substitution, which is true for Latin America, which is true to quite some extent also for Europe, France, for example, we reinforced our presence in the pharmacies.

Within cardiometabolism, Clopidogrel shows sustained growth. The molecules, the prescription of the molecules today is growing by approximately 15%. And you see on the chart, right side, a strong recovery of prescription growth when we changed our promotion methods at the end of 2005, where we reinforced our presence in hospitals and since prescription growth has been on a steady very high level. Also [inaudible] of the generics due to the fact that we never reduced our promotional efforts.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

We see then on the lower right side that the original Plavix has taken, once again, the lead. I am sure we will discuss this further during the question-and-answer session. But evidently, we are coming back to the market in a strong performance. We see today that the major wholesalers have evidently emptied their stock. What we continue in the presence of generics and observe this is a largely mail order and retail.

Now on Acomplia some words. You see that we have launched Acomplia during the second half, mainly during in the fourth quarter, now in 12 countries. And you have read during the last weeks that the launch in France is imminent. And we prepare for this launch at the beginning of March.

The penetration of the product wherever we have launched it is typical for a cardiovascular product. And I gave you two examples here. It is among the most successful launches of this respective market and therefore in line with our expectations.

We see a certain dynamic in the development of the labeling. And the most encouraging comes from Mexico, where we have a full diabetes indication, which is, of course, what we are aiming for. Following the new data specifically, SERENADE which drives us in this impetus direction which, of course, is in our strategy.

So far the success of the product is perfectly in line with our expectations. And we don't feel at all discouraged by the new reimbursement of the product in Germany. In countries we continue to promote the product with a different [axis] also in Germany. Yes, we have seen a certain slowdown of success in Germany due to the reimbursement, but we remain at a very remarkable high level.

Further positive to note that we are successful in positioning this product amongst medical [inaudible] patients and, as you see, more than 30% of the patients which we reach today and which are under treatment are perfectly in line with our labeling. And we believe that this is another contribution to increase access in the future.

Central nervous system, today's leading product, of course, Ambien and Ambien CR. We have attained a switch rate of 33% from Ambien IR to Ambien CR. And we have made significant progress in terms of access, which makes us confident that by the end of the patent protection of Ambien IR, by the end of April, we will have approximately 40% switch rate which means that Ambien CR, potentially, will be a product selling more than 1b per year, which means the new form will be a blockbuster.

And, as you see on the chart, already today Ambien CR became the leading hypnotic after Ambien IR, taking over the lead from recently launched competitors, which became flattened their performance in terms of market share since quite some while now.

I talked already before that we see the world pharmaceutical market as a much more segmented market today from a regional perspective. And yes, we have attracted in terms of our organization and in terms of allocation of our resources. And what you see on the chart on the right side is the development of headcount and sales force. I can indicate to you that our sales force total number is stable for now more than two years.

But you see that we have made significant reallocations of resources, reducing our sales force headcount, especially in the U.S., in France, in Germany. Europe is more or less stable. And you see a significant increase in the other regions, mainly China, Brazil, Mexico and the other market, Russia, where we have significant growth opportunity and where we continue to leverage also our Base Business.

This Base Business represents about EUR8.5b out of our sales. So it is very, very significant. And, once again, the importance varies from region to region. And yes, it is true, that in Europe in 2006, our Base Business, due to the intervention from the Government, due to price reductions and on reference prices, has been diminished by approximately 4%.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

But it is also true that in the rest of the world, this business which represents for the rest of the world more than 40% of total sales, has been growing by more than 4%. And we feel that this is absolutely vital to develop, especially those markets which are extremely sensitive to price, and well-proven therapeutical approaches.

And so we continue to believe in the Base Business and we believe that we do reasonably well.

Some word on health outcome, what have we obtained. You have here some examples which make us also confident for 2007.

As indicated before, Lantus sees important changes. In 2002 only 70% of Lantus treatment has been initiated by GPs. And in 2005 it grew up to 88%. But 87% of acute coronary syndrome treatment has been initiated for Plavix in hospitals, 74% of PAD, peripheral arterial disease, which remains largely un-leveraged as an indication, comes from [office] treatment.

So, once again, a strong confirmation that at least this Company, today, cannot abandon promotions to the GPs because the GP and the office initiation is of vital importance for most of our major products.

Some more data which confirms productivity and importance of our presence with the GPs. And this example, once again, out of the United States. The number of patients prophylactically treated with Lovenox increases -- still increases, and subsequently the rate of pulmonary embolism and DVT decreased.

Nevertheless, those figures for the United States are significantly, still significantly inferior to the rate of heparin innovation, the [upper 10], for example, in Europe.

If you look at the right lower side of the chart, you see that Plavix treatment, the ratio in 2006 further improved and has now reached a level which we have discussed many times during those meetings before, which is the level of Europe, approximately 200 days.

And you see also that we have been successful so that people stay longer on Plavix treatment which, of course, is of vital importance to have an optimum protection coming from Plavix.

There is a lot of discussions today, for good reason, what is the situation in the United States subsequent to the extension of Medicare. And you see here some, what I feel, impressive figures. All our major products, and I can include in this, of course, Plavix, have extremely solid positions. So additional in Managed Care, and you see that we have obtained very, very strong positions within the extension that is to play mainly in 2006.

It is therefore that we believe we have a good basis for 2007. And it is therefore that we have obtained significant progress also in making access in Europe, where we see very similar trends now, in France, in Germany and the United Kingdom, and where we take advantage of our experience from the United States.

Giving you another example, Gardasil has been more or less immediately reimbursed in most of the European countries. Also quite recently here in France. We have obtained reimbursement at very reasonable conditions for Acomplia here in France. And we are practicing our promotion approach for Acomplia in Germany, where we are being reimbursed on the official side and where we are starting to conclude agreements with private insurance companies.

So overall, yes, it is true 2006 has been an extremely difficult year. By the coincidence of controversial effects on our business which happened to an extent we haven't seen before and we hope not to see once again.

The [whole] organization has reacted to those events rapidly and adequately and the result is that this Company continued to grow in terms of sales and in terms of profit, as Jean-Claude will illustrate to you in a couple of minutes. So we feel that we've become stronger out of this year 2006 than we went into, and this gives us a lot of confidence for the ongoing year 2007.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Thank you so much.

Unidentified Company Representative

So Wayne, if you don't mind, it's up to you to talk about Vaccines.

Wayne Pisano - Sanofi-Aventis - SVP, Corporate Commercial Operations

Good morning. Sanofi Pasteur is the world leader in vaccines. Our revenue in 2006 was EUR2.533b which was a growth rate of 22.7%. Our sales in Europe, through our joint venture with Merck, Sanofi Pasteur MSD, was EUR724m.

Our business is basically consisting of a number of franchises, the largest of which is influenza. Our influenza business is over EUR800m in 2006. The next largest franchise is polio/pertussis/hib, and this is basically the vaccines for infants in the primary series. Sales were over EUR600m there.

Our booster business and pneumo meninge sales were both over EUR300m. Travel endemic was EUR239m and I'll go through each of these franchises in a little more detail to explain what happened in 2006 and what the future looks like in 2007 and beyond.

Let's start with flu. Our flu sales in 2006 were impressive, coming off a very large base, a growth rate of 27.5%, total sales now EUR835m. We produced almost 50% of the worldwide supply for influenza vaccines. And that was 170 million doses from our two facilities here in France and one in the U.S.

We have the leading market share in the U.S. with Fluzone. And we are the number one flu vaccine in Europe with Vaxigrip, also in Mexico and throughout Latin America.

We are the leaders of pre-pandemic vaccine sales, and booked revenues in excess of EUR150m in 2006.

You'll note on the slide that the U.S. sales of Fluzone had a slight decline in 2006. This is a reflection of the fact that our Base Business in 2005 we were basically the sole supplier in the U.S. marketplace. And two competitors basically re-entered the U.S. marketplace in 2006. However, we still maintained a 70% market share.

Looking forward, our focus is really in two areas. One is pre-pandemic preparedness and the other is developing the influenza marketplace globally.

Looking at pre-pandemic preparedness, in the November we received a contract from the U.S. Health Admin Services to provide H5N1 vaccine for delivery in 2007. This contract is worth to the value of U.S.\$117.9m and is another in a series of H5N1 contracts we have been supplying throughout the world.

Our focus is basically on increasing immunization rates and increasing capacity. And both of these are critical if we are going to be prepared for a pandemic. We have new facilities under production in the U.S. to produce flu vaccine. That should come online in 2009. And we are on track for the same timeframe to deliver a new filling and pack facility in [Valderoy] which will basically remove any of the current bottlenecks in providing more doses out of that facility.

In 2007 we are filing a mock dossier with the E.U. for H5N1. This is designed to prepare both the manufacturer as well as regulatory authorities to accelerate licensing of a pandemic vaccine when and if a pandemic occurs.

Additionally, we've begun studies using novel adjuvants. Studies began in January of this year and we should have the results sometime later in the year.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

We also have a partnership with Crucell, using their PER.C6 cell line. And we began trials in 2006 using the cell culture vaccine. We have also developed an H7N1 candidate, which can avert a potential pandemic strain and this is working with FLUPAN which is working within the E.U. and several academic institutions throughout Europe.

On the influenza side of the business, we expect the market to more than double in the next five years. We see growth potential virtually everywhere in the world. Starting with North America, with supply no longer a constraint within the U.S., the U.S. ACIP is expected to start moving towards universal recommendation in influenza. And the projections are that the U.S. marketplace will exceed 150m doses by 2010.

Similarly, we see similar expansion occurring in Europe as recommendations are moving down in age to the 50 to 64-year-old age group as well as the pediatric population.

In Latin American, immunization rates are still relatively low. And so there is tremendous opportunity to immunize more people in Latin America, and so most of our efforts going forward will be focused on developing this marketplace.

We've established several partnerships at the local level. One is in Mexico with [Bermex]. The other is in Brazil with [Butantan]. And we're going to see collaborations with these two organizations to accelerate the delivery of flu vaccine into those markets.

Probably the greatest potential in the long term, very similar to Pharmaceuticals, is Asia Pacific. These markets are virtually under-developed or not developed for influenza vaccines. If you look at China, for example, there are 1.2b people in China. There are only 20m people immunized today which is less than 2% of the population. Contrast that to Western Europe and North America, where over a third of the population is immunized.

If you look at India, we have 1b people and virtually no-one is immunized today for influenza. So we are developing local manufacturing presence in Asia Pacific that should come on line in the next five years which will allow us to meet this growing opportunity.

Looking at polio/pertussis/hib, sales in 2006 were up 18.5%. And this growth basically came across all the major brand families. In the U.S. we maintained market share despite the fourth consecutive year of a combination competitor. We will be introducing our own combination in 2007, which I'll cover shortly.

For India and Egypt we produced a monovalent OPD. This particular product is used to basically help eradicate polio. And we work in collaboration with the Government and the WHO. This provided growth of over 27% for our polio vaccines. And we see continued expansion of our combination vaccines based upon our acellular and IPV products. And we'll cover that in more detail.

Looking at the combinations going forward, we have two major launches scheduled in 2007. The first is in Mexico with a product that's called Pentaxim. This is a combination of acellular pertussis, IPV and hib.

Mexico is the first country in Latin America to move from OPV to IPV and from wholesale pertussis to acellular. The product was launched last month and is now the standard of care in Mexico. We expect this product to basically be used throughout Latin American and through the Asia Pacific region over the course of the next several years.

In the U.S., Pentacel, another pentavalent vaccine that combines acellular pertussis, IPV and hib. We put it in front of an FDA Advisory Board in January, called [Berpak], and the Advisory Board recommended unanimously for licensure of this product.

The product was developed in our Canadian facility and has been the standard of care in Canada for the last decade, with over 12.5m doses sold. We have a new production facility in Canada that was licensed by the FDA in the fourth quarter of 2006 which will allow us to meet the demand for Pentacel as well as other acellular pertussis combinations Daptacel and Adacel.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Looking at our pneumo/meninge franchise, Menactra was the main driver of the growth in this particular franchise. Sales reached \$242m -- euros, and we were up 36% in the U.S. over the previous year. We also experienced very strong growth in Mexico with our pneumococcal vaccine, Pneumo 23, with sales increasing 74%. This particular franchise has tremendous growth potential, and we believe that the meninge marketplace will be over EUR1b in the next several years.

Bacterial meningitis is a disease that is epidemic in Africa and endemic throughout the developed world. It has a rapid onset of action, and basically has a very high morbidity and mortality. One of the challenges of this disease is that it appears to be influenza and by the time the diagnosis is made you see very high morbidity and mortality.

With our supply issues resolved in the middle of 2006, the ACIP in the U.S. has reinstated recommendations and is now calling for all 11- to 12-year-olds, 15-year-olds, and incoming college freshmen to be immunized with Menactra. Menactra has blockbuster potential. And we have a series of events over the next three years which will basically drive it towards the EUR1b sales.

The first is the indication for 2 to 10 years of age. The submission was made to the FDA and we expect licensure sometime in the second half of 2007.

Our toddler vaccine, which will take the product down to the first year of life, entered phase III and was designated a fast-track designation by the FDA.

We launched Menactra in the fourth quarter of 2006 in Canada, and we have a new manufacturing facility that's under development right now in the U.S. The indication for toddlers, combined with a new manufacturing facility, will allow us to expand Menactra licensure throughout Europe and the rest of the world.

In terms of boosters, the booster vaccines consist of products that contain tetanus, diphtheria, pertussis and/or IPV, and are products that are used for adolescents and adults. Growth in 2006 was up 23.4%, with total sales of EUR337m.

We had a very strong uptake of Adacel in the U.S. In its first full year had EUR142m of sales. Decavac, which is the original TB vaccine, still exceeded sales of EUR100m. And we had strong recommendations in Germany for Repevax and Covaxis. And, as you can see, we had solid growth of Repevax, up 45%, driven by Germany.

Going forward, we believe that the booster marketplace will more than double in the next several years, driven by the need to immunize adolescents and adults to protect infants. In adolescents and adults, pertussis is generally a mild to moderate disease. However, for infants, it's a very severe disease, often with very high morbidity and mortality.

Epidemiology has demonstrated that infants contract the disease from parents, siblings and healthcare workers. And there's an increasing need to immunize those people in order to protect the infants who haven't completed their immunization schedule.

In the U.S. the ACIP has put forward recommendations to immunize all adolescents, adults and healthcare workers that come in contact with newborns. And looking at the epidemiology, pertussis tends to have five-year cycles, and we're right now, we're at one of the -- on a rise in pertussis. Cases in 2005 in the U.S. were 26,000. 65% of those cases came from adults who actually transmitted to the newborns.

Recommendation to immunize adolescents and adults basically is gaining momentum in Germany, and we expect this to expand throughout Europe over the next five years.

Looking at our joint venture in Europe, SPMSD, sales are EUR724m, up 5.3%. However when you look at our joint venture we -- our license for Hexavac was suspended in the second half of 2005, and if you remove that, the rest of the vaccine line was up 12% in 2006. Flu vaccine was up 18%, MMR and varicella were up 28%, and our travel endemic vaccines were up 16%.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Probably the biggest event that occurred for us in Europe was the early licensure and launch of Gardasil. And we expect Gardasil to have a major impact on performance of our joint venture in 2007. The product is now available in 13 countries in Europe, foremost being France, Germany, and the United Kingdom. And we expect launches during the course of 2007 to the other countries, including Italy, Greece, Switzerland and Spain.

Our joint venture benefits basically both from the Sanofi Pasteur and Merck product line and pipeline, and you can see we have a series of launches that will be occurring over the next several years that will help drive the growth of the joint venture.

In addition to Gardasil, which already is in launch mode, we have RotaTeg for rotavirus, a flu micro-injection which will basically provide greater protection and immunogenicity for the elderly, ProQuad which is a combination of MMR and varicella, Zostavax which is for shingles, and then Menactra for meningitis.

If you look at the vaccine business over the next five years, we expect it to more than double from EUR9.7b to EUR18b. The growth will be driven by a series of new product introductions as well as increasing immunization rates. As you can see in the chart on the right, the drivers in the next several years will be Menactra, the booster vaccines, Gardasil and RotaTeg, Zostavax, and then around -- at the end of the decade, the introduction of new flu vaccines.

Sanofi Pasteur is in a good position to basically capitalize on this growth. We are and remain the leaders in influenza, meningitis and boosters. We have a strong position in the polio/pertussis/hib. And we will be launching two products in 2007, Pentacel and Pentaxim in Mexico.

The opportunity to increase immunization rates globally is very visible, and the health organizations are driving to increase immunization rates for flu and for the pediatric vaccines. Our pipeline, which we'll touch on shortly, is very promising. And we share in all the key drivers in the growth that's expected in the next five years through our partnership with Merck and the joint venture in Europe.

Looking at our pipeline. Our pipeline is well-balanced. It consists of three types of products. We have new vaccines, like dengue and CMV, or cytomegalovirus. Those two new vaccines have entered phase II in 2007. We also have a number of combination vaccines which basically increase immunization rates and, as you have heard, Pentacel will launch in the U.S. in 2007 and Hexaxim, which is a hexavalent combination that will be available in Latin America and Asia, moved into phase III.

And then we have life-cycle management and line extension type products, Menactra 2 to 10 is an example of that. We're expanding the indication for Menactra. That will -- that licensure in the U.S. will occur in the second half of '07. Additionally our toddler development program entered phase III and it's been designated fast-track. And then the flu micro-injection basically has also entered phase III, and we're looking for licensure in 2009 in Europe.

Finally, if you look at the planned filings throughout the next three years, you can see that we have a series of new products, combinations, and life-cycle management submissions. These submissions, coupled with the need for increased immunization rates, the increased capacity we will have for flu, acellular pertussis and IPV assure Sanofi Pasteur of a solid double-digit growth in 2007 and for the years to come.

Thank you.

Jean-Claude Leroy - Sanofi-Aventis - CFO

[Interpreted]. Good morning. I suggest we look at the financial subjects. We've got the two screens here. I'll be running through the main elements, so, looking at the income statement. I think there'll be one set screen with the information and another screen we'll be using to look at things line by line, in greater depth.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Next one. Thank you. And for the other screen, can you get the beginning comments? Thank you for that.

Now, as Hanspeter was saying earlier, our business activity was fairly buoyant in Q4 2006, plus 8.4%, as you can see there. 4% for the full year. Unfortunately changes in currency, in particular dollar/euro changes in Q4, didn't actually go in the right direction for us since we publish our quarter accounts in euros. And so we can see growth of 5% in Q4, whereas, for the full year, reported basic growth of 3.9%.

If we look at the income statement, a few comments I might make on the top part here. Of course, first of all, royalties, that line. This one is being hit by the low sales for Plavix in the United States, starting August 8. To remind you of some figures, \$425m in sales between August 8 and December 31, which is much lower than previous figures. This is something we see under this line here, the royalties.

Now, cost of sales. We see an improvement in Q4 if you compare this with the previous quarter. Sorry, sorry, to correct, if we compare this with Q4 2005. This is inter alia due to the fact that we no longer have a problem comparing with U.S. generication -- generic products Allegra, and others.

So, a positive mix effect, whereas if you do this comparison on an annual basis, cost of sales dropped slightly compared to the previous year. On the other hand, the generics effect in the United States was greater than the positive effect in the product mix. Thank you.

Research and development, as you can see for the full period, R&D expenses are increasing by 9.5%. We knew this year would be a year where there would be a lot of clinical trials. Now, something -- might seem like a slowdown in R&D in Q4, limited growth. But remember, in Q4 2005, that there was a startup in R&D spending, 6.6%. For the full 2005, the growth had been 2%. So I think that puts things into perspective, to some extent.

To talk about selling and general expenses now. I think it's important to observe a reduction in Q4 and for the full year, but a bigger reduction in Q4. As from the end of Q3, beginning of Q4, we took various measures to adapt. This is fully reflected here. Now, of course, these adaptation measures are related to the various countries where we encounter problems, France, Germany, due to the extension measures taken, also the United States, as Hanspeter was alluding to earlier. On the other hand, we developed our positions elsewhere.

But, all in all, this has led to a reduction in spending. And I don't need to add, it is written here, that we have continued -- at the same time we've continued reducing general expenses, overheads. We've continued to contain spending in Q4.

This is quite interesting. If you look at the full period, selling and general expenses went down 2 points, if you make it as a percentage of sales. It's just over 28%, whereas we used to be at around, just over 30% as a percentage of net sales in the previous, in the two previous financial periods.

Other current operating income and expenses. No comments here. But I would mention that this is the line item that includes two important things. Firstly, contribution of [core] Prasco. It's a small company in the United States where we launched the Allegra off-the-shelf generic, inter alia. No change here in Q4 because we've got more and more generics [inaudible] there. Profitability, therefore, of Allegra. I'm not talking about Allegra deals have been changed, have declined.

Now the remainder. Our foreign exchange result slightly negative, ever so slightly negative, but it's still much better than last year.

So I think that this is something fairly remarkable for Q4, as I mentioned earlier. It doesn't compare poorly with the previous period, in particular when it comes to generication. But there is a Plavix impact. But this didn't prevent us from having a growth of 12.5%. 12.5% in current operating income. I think that's really remarkable. This has meant 6.1% for the full year, plus 6.1%, [don't mention] other quarters.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

You see the main factors here. Above and beyond the generics, as I mentioned earlier, we continue making efforts in R&D, up 9.5% in R&D spending. It's a complicated exercise, and we nevertheless see growth in our indicators.

When we go down a little bit more below this, as we look at what's below the current operating income, for the quarter there are two negative points, firstly costs. Restructuring costs. These are what we're calling adaptation measures. It's a question of good management, reducing spending.

We began restructuring costs. This has mainly to do with France, Germany, and, to a much lesser extent, the United States. We booked this at the end of the year. It'll start producing positive effects next year.

Now, the second point. You saw Ketek encountered several restrictions on indications, restrictions on indications in the U.S. and in Europe. The latest is dated yesterday in the United States, a further reduction in indications for Ketek. This has meant a big drop in sales for that product. You won't be surprised to hear this. This is why we had to impair some tangible assets which were used to produce Ketek. We also booked this impairment -- the total amount is about EUR214m, and we booked this in Q4.

We can see this for the full year, and let's have a look at this in terms of other operating income and expenses. This is positive. EUR536m other operating income and expenses. Positive figure. These are mainly pre-existing as of September 30 of the year. You remember the main items here. You've got capital gains, which we made in selling Exubera, also a balance from nutrition -- Animal Nutrition business.

Operating income for the full year grows by 7%, around EUR10b in all, almost EUR10b.

If we go down a little bit. Financial income expenses, of course, the cost of debt goes down, the cost of debt is going down thanks to cash flow. We'll come back to that point later. And interest rates on average have tended to go up by about 0.5 percentage point for this period.

This is also where we book capital gains. Last year we had some stakes in Biotec. In Q4, we sold our stake in Rhodia.

One item we need to look at, we need to look at this in both respects, positive and negative, net financial income and expenses.

Now tax rates. If you do the usual -- you look at taxes, you see the 29.1% tax rate. But that's not representative of what we're doing here, because the capital gains for Exubera were not heavily taxed due to the way we engineered the contract and sold to Pfizer. As mentioned, Rhodia capital gain wasn't taxed. We wanted to give you the recurring tax rate, which gives a better indication, I think, particularly in terms of the next fiscal year. So 30.6% effective tax rate.

Equity affiliates, I'll talk about generics again, clopidogrel in the United States. It's unfortunate to keep coming back to this, I'd rather say Merial performed very well this year, and this is the more remarkable, the remaining items under this heading, have to do with our sharing of profits with BMS for [Alopron] and clopidogrel.

Minority interests, same point here, but this is for the territory we managed. Minority interests go up widely because profitability, managing of two products, in our territory, Europe and the rest of the world have been good. Profitability has been good and have gone up.

Now, I think we need to try to summarize this. Net adjusted income. These figures in Q4, negative, in terms of net income and earnings per share.

Earlier I showed you some special, unusual items, restructuring costs as well as asset impairments. That's around EUR400m in all, pre-tax. Off the cuff, let me say that compared to a quarterly net income of EUR1.4b, without [inaudible], we'd have had great growth. It's no excuse. But just a piece of information.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

The quarter, I said earlier, was fairly remarkable. We've returned to substantial growth for current income, and we see this on the bottom line. You'd see it more on the bottom line if we didn't have to take those restructuring costs as well as the Ketek impairments.

Full year, EUR7b adjusted net income, up 11%. Earnings per share, this means EUR5.23 and up by 10.3%. Of course this is an improvement in our profitability rate, if you compare this net adjusted income to sales, around 25%. But we won't leave it at that. As usual, we need to look at the specific items which had an impact on these figures, but we have a better understanding of our Company's performance.

We've summarized this for the quarter and for the full year. Three headings. Let me specify, everything's net of taxes.

Interesting, the important thing, and we'll be looking at this now and henceforth, in 2007 as well. We'll be looking at the main items, so that people don't wonder what these special items are all about. We'll list these special items for you.

You can see on the list, capital gains on sale -- we should have started with the restructuring costs, actually, these have all been booked, as I said, earlier in the year. I said EUR176m earlier, pre-tax, that's EUR122m after taxes, plus a capital gains of EUR553m, including EUR100m for Rhodia, under Q4. You've got the list of the main components here.

And then a third item, which is [more sleeping] here, provisions for financial instruments, litigation, tax audits and miscellaneous. Here we need to look at the points in detail here.

The figures seem fairly low for the quarter, EUR25m, and the full year EUR38m, but in reality this covers several things. For instance, if you look at Q4, I would say, on the one hand, the positive element, the favorable outcome of some tax audits, there were some provisions for tax risks. This has meant a write-back of EUR105m, a write-back in provisions of EUR105m.

Earlier I also mentioned some impairments of industrial assets for Ketek. And here you can see this net of taxes, EUR79m impairment of Ketek assets, are the two main items for the quarter.

And then, conventionally, you've got a change in financial instruments, as you see, CSL. This is the Australian company that Aventis Behring was sold to. Unfortunately some traditional provisions for the investment portfolio mark to market. This is the minority stakes that are lifted.

So all this -- are the special items that were negative, EUR168m negative in 2005, EUR469m in 2006, total after tax. Fairly neutral for Q4 2006, which means excluding any directed items, growth in income -- slight growth in income for Q4. Unfortunately slight reduction in earnings per share in Q4, and particularly for the full year.

We talked about this growth earlier. 6.6% in actual terms, approximately EUR6.6b, and 5.9% earnings per share, EUR4.88.

One technical point I'd like to make here. We've shown you -- give selected items, these special items, I've said we'd continue using this layout in the future. When Gerard Le Fur in a few minutes comments on guidance for 2007, he'll be doing this based on the adjusted income, excluding the selected items, these special items.

Cash flow, I think it's fairly easy to conclude that, if you look at full 2006, we can say there's been an improvement in cash flow, reduced net debt by EUR4.1b after having EUR4.3b in 2005.

Another point. EUR7.6b operational cash flow may seem like a big change from 2005, but remember they were asset impairments included in our earnings, which is why there's a slight increase in cash flow.

And we can see the working capital. Not many points on working capital compared to June 30. The situation's a little bit better than June 30, we've used up EUR1b of working capital. I wouldn't say much about working capital requirements for operations.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

It mainly had to do with other assets and liabilities, and here we're talking about tax effects actually. You know, the fact that there's a lack of synchronicity. You've got taxes that are booked at one period and paid in another period, for example, tax payment in December, and we have to be careful in calculating these, [inaudible] this year again. Sometimes we have to pay a little bit more in advanced payments to make sure you don't end having to pay a penalty subsequently if you've made a mistake in that advance payment.

So these are the main items that you are seeing here. All of our working requirements, if you look at it on the balance sheet its 11% of sales, which is still something fairly modest.

Now last line, investments going forward of [EUR1m], this includes acquisitions products, including recovery of our rights for Plavix and Rimonabant in Japan. Other industrial investments grow slightly compared to last year, efforts we've made in Vaccines. There is a growth here compared to last year.

Acquisitions, this is mainly Zentiva this year. It was Hoechst minority last year. Asset sales, disposals a little bit of Exubera. This is net of taxes, so there is no confusion. Second element here Rhodia. This is part of the EUR1.2b, mainly [Robacra] last year a stake of 50% in German chemistry.

Share increases, [different] share shifts dividends, this relates to the points I said earlier. And the level of net debt at the end of this fiscal period, which is EUR5.8b. You can see over a two-year period we've reduced debt by EUR8.4b. We had EUR14.2b the previous year. We were at EUR17b after the summer of 2004, during the acquisition. So you can see that we are very much in sync. This is right in line with what we've indicated to you at the beginning of 2004. Gearing has gone down a little over 12% at the end of 2006.

The balance sheet, not many points here. Let me just say since the dollar has gone down the balance sheet is -- the weight is lower, and this is mainly due to the currency effects above and beyond the conventional depreciations. We've communicated for two years now we will have this depreciation for many years to come, these intangibles in our balance sheet. This is basically all I wanted to mention on the balance sheet itself.

To talk about the dividends now, the Board of Directors decided to propose an increase in the dividend for the rest of 2006 up 15%, which is a faster increase than net adjusted earnings, excluding collected items. EPS was [plus 5.9], a faster increase than adjusted earnings per share, plus 10%.

So, what we are doing here is -- and we are pleased to see the improvement in our net debt. We were EUR5.8b at the end of the financial year, and this is in step with what we've said when we began the operations.

Includes payout rate when Group's debt had been cut substantially, well the Board felt that the time had come to propose to shareholders bigger growth in dividend and growth in earnings. So, the payout rate 32 -- it goes from 32% to 33% this year. There you go, thank you very much.

Gerard Le Fur - Sanofi-Aventis - CEO

[Interpreted]. The next speaker will be Marc Cluzel, who will be talking to us about the R&D portfolio. He will be joined during his presentation by Pierre Chancel. They will be speaking together. We said that to you earlier.

Marc Cluzel - Sanofi-Aventis - Head of Research and Development

[Interpreted]. Before I begin I just want to say a few words about the general spread we've been making [inaudible] in. And we have, for today, we realize that we need to know better, but particularly to better understand our portfolio.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

In so far as our Phase IIb and III products have increased by about 25%, we decided to make a rather complete presentation of all our Phase III products, and in particular to put these products into their therapeutic perspectives. Obviously it takes more than one product for a company to be successful, but its -- generally it's the whole vision of a therapeutic category.

Of course, the other side of that is that we have 124-page presentation. So we will be going through the various slides rather quickly.

You will have ample opportunity to ask your questions later on. And maybe I can share that we will be holding an R&D meeting on September 17, this year, a special R&D meeting which will give you an even better opportunity to understand our portfolio and ask all your questions, as well as understanding our philosophy.

Well, first part of the presentation, this is the usual chart we use to present our portfolio. It can be analyzed in various different ways, but the number of molecules is, broadly speaking, stable.

There is an increase from 35 to 46 molecules in Phase II and III -- IIb and III, that is. And would be also be -- in the clinical field we have a total of 17 molecules that's preclinical Phase I. If we take our base medicine -- our Base Business, gives a total of 87.

Also, interesting to bear in mind that the long-term investment has ultimately paid off. We've always felt that the central nervous system was probably an area that we had to develop in, in the pharmaceutical sector. Well we know have 27 products in this sector, with 10 in Phases IIb and III.

Likewise with Oncology, the number of products is up to 18 in all. And, of course, we still are very, very strong in our preferred area, that is the cardiometabolism and thrombosis [access].

I am just going to comment the top of this slide, that is slide 57. 2007 and 2008, and just bearing in mind that in pharmacy we have 12 products that we have planned to submit in '07 and '08. But, for information, we felt that biotinylated and [Idranix] and Idaparinux was one single product. To these 12 we could add the six vaccines, which would give us a total of 18 molecules that can potentially be submitted in '07 or '08.

Here again our work has ultimately paid off, because if you look at the central nervous system we have four potential products here, two in the field of depression, one for Alzheimer's, and another one in the -- another preferred franchise which is sleep.

In Oncology we have S-1 with the VEGF Trap, and Alvocidib. As for the changes in the main portfolio, one product has yet to be for this year put in, but S-1 is in. So, we are getting closer to our goal, and we have a relatively stable number of products.

I am now going to the R&D proper, we are going to do a duo with Pierre on my right, or your left as you prefer.

Pierre Chancel - Sanofi-Aventis - Head of Global Marketing

[Interpreted]. Good morning everybody. What Marc Cluzel and I will be doing is that we are going to talk to you about the challenges, the strategic context and the main thrusts as regards our product strategy.

We are going to focus mainly on three areas, cardiometabolism, central nervous system and oncology. They are the three main areas. Each time we will be telling what the main aspects of our product strategy are.

Now, I will be telling you what we are doing, and because it's our business we will be aim to improve the public health, which obviously has clinical benefits, but also economic benefits, cost-benefit analysis. But we will be looking at the broader picture for each of these pathologies.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

We are going to deal with the information that you are probably familiar with. This is the cardiovascular mortality rate over the next 20 years. This is a projection, of course. We are talking about non-communicable diseases, but the main cause now and in 20 years time will be cardiovascular diseases, followed by oncology or cancer.

Secondly, if we look at the global cardiometabolic risk factors, we can normally look at risk factors individually. You have the established risk factors, such as LDL cholesterol, hypertension and diabetes. But there are a number of new risk factors that have emerged. Here you have the overall definition of a cardiometabolic risk, that's the EDA's or the ADA's definition as presented at its last conference in June 2006.

The upshot is that we need to take cardiometabolic patients into account as a whole, from a global point of view. Now, there are connections between these risk factors so there -- there is a known co-existence of risks in patients, but also co-morbidity. And, of course, we need to take a new therapeutic approach altogether.

This slide, really what I am driving at is, well, three things. First of all, one I've already mentioned is the co-morbidity. This [inaudible] co-exist in patients. Now, without going into details you see the various factors, morbidity factors on the left.

Secondly, because these risks co-exist you don't just add one risk to another. Risk actually increases exponentially the more factors you have. Now, we have a study called Interheart, which shows that the risk actually increases exponentially when there are more than one factors of risk.

Thirdly there is a continuum here, there is a real connection over time between the way the disease develops and the way it's treated. Existence or co-existence of several factors can lead to coronary events, [ADCs], strokes. And, of course, we also then need a secondary management, closer management of risk, post-event management with strategic therapies.

Now before telling you what we do and what we want to do, and the last thing I'd like to say is that the number of patients concerned by global cardiometabolic risk is increasing sharply for two reasons. First of all, if you take obesity or diabetes separately, you could talk about diabetes being the epidemic of the [third] millennium, 150 per 1,000, we expect that 250 or 280,000 by 2020 that's really an epidemic.

Here we are working on guidelines. Science is still moving forwards. Guidelines are more and more aggressive, because we see the benefits of that, treating diabetes aggressively. [IV] is low as 7.5 points, now the figures is 5. We now -- it is over 6.5 might be as low as 5 in a few years time.

Likewise with the waist circumference, the definition has increased, like with the high blood pressure and LDL cholesterol. So, the guidelines are more and more restrictive, more and more stringent. So, we are undeniably faced with a public health issue, and we are going to have to treat these patients appropriately.

Now, what about us, what are we doing? Well, we've committed ourselves for two reasons. First of all, we have a portfolio of products for which we are the reference prior to the product. We are the cornerstone of each of these risk factors, be it the level of thrombosis, thrombosis, diabetes. When you take all these factors into account they are all covered with Acompla.

Now, how to continue with this architectural approach, I would say that Acompla is really the keystone or cornerstone that enables us to say that we, at Sanofi-Aventis, are best positioned in this global therapeutic management of risk factors.

So, we have our products, of course. But secondly the strategic goal and strategic reality are aligned. If you want to treat patients and manage patients globally well you have to manage them with your products, but with everything else we do.

There is no real mystery here that we use our data, clinical data, primary prevention data, real life data, registers, support through patients, through doctors, partnership programs with the doctors and with carers. But rather than mention everything we do and can do, let me give you two or three examples.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

First of all, most of our primary prevention programs in 2007 concern over 40,000 patients. These are as primary prevention trials. As for the registers, look at what happens in real life. You see how these patients develop to see what the impact is on them. We keep registers on our various pathologies. We actually cover 400,000 patients with our registers, which is to reach -- address all the registers that we keep.

And, of course, we have taken a number of initiatives to provide support, back up to patients, doctors in areas such as insulin, to increase early [insulinization]. So support to patients, doctors to nurses, patient support centers, programs, information programs.

And also to [compare] the ideas to ensure that people understand what this disease is all about, how this disease can be treated, how patients' expectations can be managed, and how to teach patients to take their medication properly, not just in the short term but in three, six, nine months time. We also have call centers. We provide information day-to-day information, at the request of patients, but with the help of doctors and medical staff.

So, as you can see, we have taken a large number of initiatives. So this is what we do, this is what we are doing to change things in the cardiometabolic spectrum.

Now, this brings me to diabetes with Lantus. Now, to keep things simple, out of 100 patients in type 2 diabetes patients, out of every 100, 10 -- while diet exercise is part of the treatment I should add that, that's the green column, the first one, but out of 100, 10 are on Lantus.

The top right, which you see is our early insulinization strategy. And we think that patients should be treated earlier. In fact 70% of patients treated with insulin have an average hemoglobin rate of over 8, because this means they are simply getting -- the situation is deteriorating every day. So we've shown that our strategy pays off.

On the bottom right you see that we still have growth potential in substituting patients on pre-mix, which is the long compromise. Pre-mix treatments are treatments that provoke a hypoglycemia if they are too aggressive, and if you want to avoid hypoglycemia, people are not properly controlled. So Pre-mixes are not a satisfactory solution.

You see the potential on the left-hand side, with patients treated with 1, 2, 3 or 4 orals even though the actual number of patients may not be very high. Now does that pay off, does it work? On the left-hand side you have the market share in the U.S. insulin market. You have the market share of Lantus on prescription, of which Lantus is now the top-prescribed insulin drug in the U.S.

Now by meal time, within the left-hand side this is [inaudible] all these rapid insulin's take [more] time. And as we want to feel chuffed about what we've achieved, we look at the absolute value, as the absolute value, or the absolute volume of Lantus described as a straight line rising on the right-hand side. Little yellow color is Januvia in the U.S. This is a product that is beginning, the product that is affected is Byetta, it's not us.

The instantaneous pen we've been talking about the last four years or so, in 2007 we will be gradually launching SoloStar. Launches will be staggered from one country to another. This is a disposable pen, state-of-the-art disposable insulin pen that has significant competitive advantages, advantages over the best-in-class in the pharmaceutical industry at the present moment. So here again we have reasons to be confident.

Now I am not going to go into the details here, but here is a detailed plan. But just let me specify that on the bottom right, Origin prevention of CV events in high risk.

12,000 patients with [inaudible] cells are these Type II diabetes patients, had they been treated from Lantus from the very onset. By comparison with a conventional treatment, and, of course, this has enabled us to show that Lantus from the very start is the better solution.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Atherothrombosis, which is a single disease with a -- that affects a number of parts of the body. You see the number of patients concerned. The aetiology is very impressive, we have the figures for cerebrothrombosis, cardio PAD, peripheral arterial disease. And these different areas can co-exist.

Let me stress just one mortality which is a lower limb region. Now, with one of our programs, called [Reach], we've been able to show that after a year, one in every five patients diagnosed with lower limb affection is hospitalized. On the left hand side you see the reasons for this hospitalization, usually from the co-morbidity. So, it is a public health issue.

Secondly if you look at the right-hand side, you see the number of PAD patients that are not treated. 70% in all. The Basal guidelines date back about six months. This is data taken from the U.S. market, where we have use of Plavix, of course.

Now the development plan here for Plavix, without going into details, here you have it on the chart. But, up until 2007/2008 we will be increasing our penetration of different market segments in 2008 onwards. We will really be focusing on the duration of treatments, because the longer the patients are treated the more better they're protected.

Thrombosis now, the objective is to avoid or manage clots if they're -- this is thrombosis. It's not arterial when in veins, but venal thrombosis, even if it's of different origin, even if it is -- it manifests itself acutely, the consequences are nonetheless the same, it's clotting. And, of course, the danger is probably embolism.

Let me just stress one point here, that's the prophylaxis of pulmonary embolism, we know that we are perfectly capable of defining where the risk patients are, we know how to identify them. Just a few figures here, in 2005 25m [sic -- see presentation] patients were eligible but were not protected, they were not treated. These are medical prophylaxis or surgical prophylaxis.

Now if you look at the patients treated, one in two was treated with nonfractionated heparin. But if we say that we have a public health target, and if we have Lovenox whose superiority over nonfractionated heparin has been proven, well in cardio-vas that's fine. There has been a study that has demonstrated the superiority of Lovenox over these nonfractionated heparins, 40% proven in medical prophylaxes. That is a big improvement in terms of public health.

So, the Lovenox plan here, Acomplia. Well Acomplia. This is a slide that I've shown you several times already. But, of course, the product with its development plan, as the studies are coming on stream, it's keeping its promise. The RIO study 50% direct effect on diabetes, on dyslipidemia.

But then the SERENADE study that Marc will show you, but also the initial studies that demonstrate the benefits in abdominal obesity, obesity that is a consequence of all the physio, pathological effects. So, Acomplia, that is really delivering as we near the results of the life cycle management program that I won't recall today.

Primary prevention, CRESCENDO, great study. 15,000 patients showing the reduction of events in treating patients with Acomplia.

So, over now to Marc who will tell you about SERENADE case.

Marc Cluzel - Sanofi-Aventis - Head of Research and Development

[Interpreted]. Start off with SERENADE, the results presented in December. Just a quick reminder of some key points.

We can, indeed, consider in looking at this slide that Acomplia is achieved significant reduction. 0.8 reduction in efficacy from base line. The important figures, 1.9% reduction in HbA1c in patients with a score of below 8.5% at baseline. If we take 7% hemoglobin, we achieve the results here. And, of course, the target is no longer 7%, but 6.5%. Remarkable anti-diabetic effect.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

But, of course, Acomplia is not just an anti-diabetic. It's far more than that. It is, indeed, a product that can increase HDL. 10% increase. And 16% in triglycerides.

Another major problem faced by type II diabetic patients is weight gain. Thus far few products are capable of lowering weight, [DP34] to a lesser extent. And you can see that in this study there is a reduction of 7 kilos in weight in these patients, with a reduction in waist circumference of 6cm. This does, indeed, confirm the positioning of Acomplia as an agent to treat. It's a multi-factor agent to address several causes of cardiovascular disease. In addition, a major focus, major effect in diabetes.

Another study not yet presented, a Japanese study DRI5747. Why a phase IIb clinical study in Japan? Simply because they don't have the same definition of obesity as Europe and the U.S., so we have a specific study for Japan. Here are the inclusion criteria.

What's interesting to note here is that for the first time we were measuring visceral fat. We've spoken to you a lot about visceral fat and subcutaneous fat. And, of course, weight circumference reduction was linked to visceral fat reduction. We have never demonstrated it. So first the results of the study. It really is quite an impressive. Study after study, exactly the same data, the same lines we have for weight or for waist circumference.

Just a brief scientific point. This is replicated in animals. We can really see that we've affected an important point in the body, so there would be greater fluctuations. So this constancy really does demonstrate the importance of the mechanism of action.

On the fat, well on the left hand side of the page, how by scan, visceral fat is measured. And on the right-hand side two patients, two patients with exactly the same fat area, but one at the top where you can see that is white, far more visceral fat. And the lower chart with far less white in the stomach, far less visceral fat, but far more subcutaneous fat.

And when we look at the efficacy of Acomplia on these end points, well what do we see? Efficacy both in visceral fat and subcutaneous fat area. When we compare at the relative efficacy, we see far greater activity on visceral than on subcutaneous fat. Perhaps the simplest way of illustrating this would be at 10mg, we have a relatively modest reduction in subcutaneous fat where there is a significant reduction in visceral fat.

We also see that at the end of treatment for the 20mg group, percentage of visceral fat as compared to overall fat has declined during the study. So this is, indeed, a confirmation of the beneficial effects of Acomplia on visceral fat. Visceral fat correlated with waist circumference, in turn correlated with an increase in the cardiometabolic risk.

In terms of safety, well, of course, we should have started this development in Japan. Great safety profile you can see here. There are fewer patients that exit the study with adverse effects in the 20mg group than in the placebo group.

What's also interesting, difficult to know whether it's specific to the Japanese population, the absence of nausea in the list of adverse events for depression. This may be a cultural factor in so far as depression is not widely reported in Japan. But for nausea we need to continue development. We currently have studies underway in phase III in Japan. It'd be interesting to see if there really is a different nausea. So that was Acomplia.

Still in diabetes we have a glucose -- a renal glucose inhibitor. Just to describe what we have in diabetes, there are products that inhibit glucose re-absorption and the most attractive products that promote the reentry of glucose and insulin secretion. This is the central portion here, working more on the concept of insulin resistance.

But there's another portion that, thus far, have not been explored which was glucose elimination. Part of the glucose is filtered and then re-absorbed in the kidney through an enzyme. And in the absence of this enzyme there's a loss of glucose in the kidney. Glucosuria in normal -- in healthy patients which would be a loss of 720 kilocalories per day. So we attempted to determine by inhibiting this enzyme to increase the elimination in the animal, in the mouse.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

On the left, the glucose. And then HBA1, the glucose impact over the long term. And there's a dose-dependent reduction. And in treating the mice we improve both the blood sugar and HBA1C. And this is also apparent in the right-hand slide where rats had far better tolerance of glucose injections.

In humans, there's a phase I study. The results are reported. Great dose effect on the glucose output in healthy patients, not in diabetics. Additional glucose output in healthy subjects is about 20 -- between 20 and 20% of output. Glucose output of normal is zero, but only because there's the re-absorption.

So what can we expect from this type of product? Certainly not a product to treat the additional cause because it's really the Acompli-type products that are the most beneficial. Addressing the -- treating the condition, but in association, very interesting products in order to improve blood sugar. Better glycaemic control. Low risk of hypoglycemia. Can also be combined with other anti-diabetics. And that's -- the safety profile is very attractive.

And no weight gain and possible weight loss, in fact. The phase IIb program is underway. The results are expected at the end of the year, with start of phase III next year.

Cholesterol, not as innovative as the previous product, but a great supplement because, with this product, we have an activity that is comparable or better than ezetimib. It can be very useful in association with statins. And phase II is ongoing.

Just here to address two products. GLP1, end of phase IIb. GLP1 and AVE1625, CB1 antagonist for an indication that is tested in IIb. Indication that is not obesity alone, but obesity and dyslipidemia. So that's results during the course of the year. Early phase III next year and likely results.

Thrombosis. Rather complicated because there are different indications in which we can separate. We can have a chart, acute, the post-acute, the week or the month and long-term, the month or even the year.

And we can also divide the conditions. We have the venous conditions. Either we can have primary prevention. If you've undergone hip surgery, for instance, anticoagulants during your hospitalization stay. Anticoagulation inadequate or you're suffering from cancer and you haven't received any prevention for onset of thrombosis. And so in that case you're treated for venous thrombosis. Knowing the treatment is, of course, far longer than prevention. At the same time this treatment is administered, there's also prevention of relapse. That's for venous.

Let's take now ischemic stroke. Blood clots from the atrium. And this is, of course, prevention of strokes, ischemic strokes, of [anti] vitamin K activity. And then there's the acute coronary syndrome. And here, again, either short [term], the otamixaban, we could have also included Plavix, because Plavix not an anticoagulant, and anti-platelet covers acute, post-acute and long-term in ACS.

As you can see, we have various products in each area, well, no more than two. We have AVE5026 and SR biotinylated idraparinux for venous thrombosis. And in stroke prevention, we have two products in the acute portion of ACS. I'll return to the difference in a moment.

Sorry, this is a rather crowded slide. I'll just run through it quickly at the top. The mechanism of action already described. A biotin hook on the idraparinux compound. The binding hasn't in any way changed the idraparinux. And then avidin, in the event of bleeding, which binds to the biotin. And avidin biotin idraparinux, in a minute, is absorbed in the liver, reducing the risk of bleeding.

We have obtained the possibility of achieving this development of DVT with idraparinux. And we have two studies underway. The first, just to pick up the idraparinux studies in venous thrombosis. We have EQUINOX. EQUINOX which is for patients with DVT. 26 weeks. At the end of the 26-week period we look at these patients, we look at the avidin activity. We have subgroups

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

and we'll inject avidin and determine the anti-10A activity in the other placebo and see what happens. That's for venous thrombosis.

Now, in other patients with pulmonary embolism, different durations of treatment depending on the seriousness of the condition. Investigators can include patients either at 13 or 26 weeks.

In light of the Amadeus study, that are quite interesting to be presented in July in ISTH, we've decided to use, building on the Amadeus experience, we've decided to launch a program in arterial [fibrillation] with idraparinux. That's due to start at the end of this year.

So just briefly the pie chart that's illegible. We forgot to add something. There's a lot of talk about a product, once daily, oral or an injection, subcutaneous injection, is it interesting. Most people answered well, oral treatment once daily is far better. So we're getting the feedback from investigators on Amadeus. Most patients were disappointed no longer to have a once-weekly injection, found it very convenient.

Here's the result of an in-house survey addressing investigators, what mode of administration, once daily oral or subcutaneous injections once weekly, but which really does confirm our patient experience with Amadeus. 41% of physicians would prefer a subcutaneous form once weekly.

No problem with interaction with idraparinux which, in the elderly population, possibly, that's very useful.

Idraparinux biotinylated factor 10 inhibitor of coagulation, a mixed inhibition through the pentasaccharides of factor 10, and at the same time, factor 2 of a semi-heparin of synthetic origin. So this is venous thrombosis possibly for risk benefit because really in the scope of anticoagulation it's not so much the efficacy, but the risk benefit. If there's too much bleeding then you lose the advantage of the treatment.

So this is both in the primary prevention of VT, with a drive study underway. We've recruited half the patients for that. And in the acute coronary syndrome, here we have a duration of action longer than [otamixaban] and greater efficacy than [otamixaban]. So really the severely affected ACS patients and patients who, most times, will undergo a coronary procedure.

SHINE, that's a big one. 1,200 patients. It's a pivotal study. Results expected second half of this year.

Increasingly there is a view that we cannot address anticoagulation with a single product. And it's increasingly beneficial to have a product adapted to each segment. There's one segment that lends itself well to one of our products which is that of VTE, venous thrombolytic events, and cancer.

Relatively frequent, 15% of deaths in cancer patients due to fatal pulmonary embolism. And we know subsequent to a study, and this is on the right-hand side of the slide, that mortality is significantly greater, doubled, in cancer patients with VTE, venous thrombo-embolism, as compared to those who haven't. So in venous thrombo-embolism, obviously the risk is increased with a central catheter. But in this population we have decided to develop [AVE 5026], which is an ultra-low molecular weight heparin which has yielded excellent results in its first clinical trials.

We are about midway through recruitment. 400 patients recruited. And results expected. In order to define the dose, what we're after is, of course the risk benefit. Will we start development where the bleeding happens? And that's in surgery. That's why we have phase IIb in knee or hip prostheses before switching to oncology.

Otamixaban, this is an ideal profile for ACS patients with short-acting direct selective very short half life, suppressing the risk of bleeding. If you stop the product it means that the efficacy is no longer there. And no doubt in moderate intensity coronary events, where the cardiologist wants the patient to come out rapidly after intervention, so otamixaban is ideal for these patients.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

The SEPIA study, that's a wide-ranging study in patients who'd undergone PTI. Excellent safety profile. As I was saying, good safety profile with predictable and dose-proportional anticoagulant activity. Phase IIb study initiated. Recruitments underway. That's SEPIA ACS where we are testing various doses of otamixaban. The idea here with the last arm is to replace the use of Heparin.

So as far as thrombosis is concerned, we have already said everything there is to say.

Cardiometabolism. Just a brief word on this. We already talked about the results. But we would like to give you a very comprehensive view of our portfolio. NV1FGF, as you know, FGF increases neovascularization so that there is an advantage where patients are suffering from lower limb arteriopathy, with potential risk of amputation, in providing patients with such drugs.

Just before I go into the study itself, in terms of the cost for Company, this amount has been estimated about \$10b.

Let me just finish on this slide. We have completed phase IIb. We will begin recruitment for phase III next quarter.

Just a brief reminder, you have already seen these at the previous analyst meeting, so just the effect on amputations. On the left, all amputations, including toes, for instance. On the right, major amputations, the ones which are the most costly for society as a whole. And these start at the knee level. Very great effectiveness there.

This is the design for the phase III. You can see that there are four injections every two weeks, a 12-month follow-up. This is one of the first, or perhaps the first gene therapy product. It has [multiple] local action. Of course, you know one of the associated risks of gene therapy is cancer onset. And another point is that when you work with gene therapy, it's important to monitor, to follow up the patients for a very long time. Now here we're talking about very high-risk population, so long-term survival is actually not so much of a concern.

Celivarone comes next. Here we have interesting outcomes since we did find activity in phase IIb. The problem is simply that we found the same levels of activity for all dose levels in phase IIb. And we had a similar experience with dronedarone. So that we decided to return to dose ranging with lower doses and had to initiate another IIb phase study which should start up towards the end of the year.

The reason it will only start up at the end of the year is because by then we will have the final formulation. This will enable us to avoid subsequent bio-equivalence studies.

Next we come to Ilepatri. The mechanism of action is one which will be familiar to you, double mechanism, blocking formation of angiotensin II, ANGI from ANGI. And, at the same time, in addition of degradation of ANP, BNP and bradykinin. As you know, the sodium overload is something which can be combated thereby. So for kidney failure, heart failure as well as VT indication, this can be very useful.

The proof of concept, as you will see from the top line here, we had a study of 35[mg] reduction. [Angioedema], this potentially was concerned, so the phase IIb study which is currently underway, we're about halfway through. So far everything is proceeding smoothly. We're keeping our fingers crossed. It's going to be essentially focusing on safety. And as a calibrator, so to speak, we used losartan, both in terms of efficacy and of safety, bearing in mind that the maximum threshold for angioedema during development has been set.

So we will soon know the outcome on that one. 52-week follow-up to cover all our bases in terms of intolerance to the product and make sure that we have a safe product.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

There are just two products we haven't mentioned yet in cardiovascular. Dronedarone, recruitment has been completed for that. We will have the outcomes in the first quarter of next year. It's a one-year treatment. And this combined inhibitor, 5-HT1B/5-HT2A for peripheral arterial disease.

And I'll give the floor now to Pierre.

Pierre Chancel - Sanofi-Aventis - Head of Global Marketing

[Interpreted]. Well, thank you. Let's move on now to the central nervous system, and CNS. These are diseases which are under-diagnosed, under-treated. There are a number of reasons to this. We are understanding more and more about these diseases, such as sleep disorders or depression or, indeed, Alzheimer's, for instance. And this is enabling us to work towards better management.

Now, what is really at stake has yet to come. The epidemiology data increased with age, certainly for Alzheimer's or insomnia. And when you project the population data forward with aging populations, well, mechanically, inexorably there is an increase to be foreseen in the disorders or diseases.

If we look first of all then for the three key problems we'll be looking at, depressive disorders, Alzheimer's and insomnia. Starting with depression. You have initially a progression to disorder. We start to treat. There may be an improvement in response, potentially with the relapse. We may need to treat again, potentially other relapses which may occur.

But I think the most important is the figures which you see on the bottom three lines. After a first episode, the risk of a second is 50%. After a second, however, the risk of a third is 70%. And after the third, the risk of a fourth is 90% in terms of relapses into depression. So we're looking at a disease which is insufficiently managed, but too late in the game and not in an adequate fashion, furthermore, so that perhaps part of the solution can come from better management at the early stages.

And when it comes to treatment in terms of depression, the picture is not a very rosy one either. About 50% of patients do not respond appropriately to an adequate treatment. Only about 30% achieve full remission.

In terms of safety and compliance, more than one in three patients stop treatment during the first month, either because of adverse events or because of lack of symptom relief. So there's room for therapeutic improvement there.

If you look at this chart here, you have the treatment algorithm which exists today. They initiate treatment with first-line therapy. If it doesn't work they increase the dose and they add another. The use rather, instead, second-line therapy. And if that doesn't work, they use both products together.

The problem is that we're looking at about 10 to 20% for second and third-line therapy combined. All of the products on the market -- virtually all the drugs on the market have similar mechanisms, so the combinations of drugs, of course, may heighten efficiency but they will also render more acute any adverse effects.

The opportunities on the right for improvement in terms of treatment for depression, improve either efficacy or tolerance, at least the therapeutic index in terms of benefit and safety.

And there is the possibility of combining drugs with different action mechanisms. Saredutant is an inhibitor, whereas amibegron is an antagonist. So you have to separate mechanisms here, which enables, potentially, new approaches to depression management to be envisaged.

Turning to sleep now, as you know, although many people suffer from sleep disorders, it is actually quite complicated to gain a clear understanding of each specific patient case when we start looking at things in greater detail. We have been able to

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

identify three orders, ranges of issues. Induction problems, maintenance problems, maintenance of sleep patterns and poor sleep quality.

We have seen increasingly that sleep fragmentation, build up of sleep dep eventually leads to insulin resistance, to further weight gain and diabetes, so that there is associated morbidity and mortality between such health problems and sleep disorders, which shows us a rather interesting direction for strategic approaches in terms of our two key drugs here, eplivanserin and volinanserin.

Moving to Alzheimer's now, as you know, only the symptomatic treatments are available today. With symptomatic treatment, of course, you are only going to very briefly, fleetingly improve the patient's score in terms of cognitive function. But since the treatment has no effect on the progression of the disease itself, this will only be a passing improvement. We would need to find drugs which would actually affect the disease itself, its progression rather than simply its symptoms. And that is the range of issues around xaliprodin.

So Marc is going to tell us now about the results of our study.

Marc Cluzel - Sanofi-Aventis - Head of Research and Development

[Interpreted]. We're going to be talking about major depressive disorders, MDD, and generalized anxiety disorders, or GAD.

Just a brief point on what the previous speaker was saying which I think is truly probably the key point in this [one], we are likely to see movement towards better treatment of depression. The better treatment we can provide for events and, in particular, for the first event in terms of depression, the lower the risk of relapse will be.

So what we've been trying to do is to work towards a new paradigm whereby we would be able to achieve this. In other words, effective management of the first episode.

There has already been a move in this direction in clinical practice. As you know, we carry out our studies over an eight-week period in many cases. And there are some representative authorities in psychiatry which have been advocating increasingly ensuring that the patient's first depressive episode would be [technical difficulty]. [I'm sure] that would be a lower likelihood of relapse.

As was mentioned by the previous speaker, about 50% of patients do not respond adequately. Let's say 30 to 45%. In some cases they have a partial response. In some cases they are non-responders. The poor response level may have to do with the need for the patient to be treated with different therapeutic classes to achieve improvement.

Then, there are concomitant medical or psychiatric disorders and sometimes there may be a familial predisposition to a poor response, in particular the serotonin transporter gene polymorphisms. So a need, then, for new mechanisms of action. Many patients, as was mentioned also by the previous speaker, will stop because of adverse effects, such as a dry mouth or sexual dysfunction, for instance.

It's always an interesting thing to do, when we are looking at depression or similar CNS problems, to look at how things can tie in with, say, diabetes or cardiometabolism, because in the latter two [concepts], you often have a number of different therapeutic agents which you can use concurrently, whereas when it comes to CNS problems and pathologies, in many cases you just have one therapeutic class that you can use.

So where do we stand currently in terms of depression? We've been working very hard indeed. We have three broad approaches, let's say. First of which is Beta3 agonist, second is in phase III. The second has to do with neurokinins, NK2, with Saredutant in phase III, another product which is in the pre-clinical stage.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Then, aside from this NK2-specific antagonist, we also have another antagonist which is NK3 and NK2 antagonist. Then, there are V1b antagonists and CRF1 antagonists. Working with probably less secondary effects is a promising product among the ones I just mentioned, the one against V1b, which is SSR149415. In other words, as compared with our competitors, we have a pretty impressive arsenal of tools to fight these problems of depression or anxiety.

Now, Saredutant is a product which you are no doubt familiar with, a non-peptide selective antagonist of the human brain NK2 receptors. Administered once a day, we have a very good tolerance profile. I'm afraid I've perhaps approached things in a slightly different order from the way you see them on the screen. I hope you will forgive me for that. Could it be that I'm missing a slide? No. They all seem to be there.

Let's see. So these are the ongoing studies. Just getting my bearings here. Here we go. The results from phase IIb studies of Saredutant are encouraging. Until now, when we looked at depression issues, we tended to exclusively base our assessment on positive changes in the Hamilton scale. But, increasingly, the question is becoming has the patient returned to normal or not?

And in this respect, we have the right-hand part of this slide, the percentage of patients who have a Ham-D total score under eight, in other words the remitters having achieved a degree of normalization.

I'm not sure that we can really define what is normal, but, say you have a Hamilton score under eight, what you then want to do is to try to consolidate to maintain this remission. You don't always have symmetrical proportions between the patients who achieve a total score under eight and the ones who continue to consolidate their remission. So I think perhaps with NK2 antagonists and inhibitors of serotonin or other combined products, we will probably have a solution for that.

[The full] results phase III Saredutant. These findings are mixed. They're good findings, the extent that, as you can see, for the first two studies, the EFC5575 and EFC5573, you have to increase the placebo, which means there are two studies that are statistically significant versus placebo.

One result's less good, EFC5571 and EFC5572. Here, we see crosses with the placebo, which means these two studies are not significantly -- statistically significant versus placebo.

This is fairly standard, because, in most instances, in fact almost all anti-depressive agents, you've got about half these studies that are statistically significant and the other half that are not statistically significant, which is a slight problem to register the product, because in the four studies where the two -- 5571 and 5572, there's another anti-depressive agent, paroxetine, in these two studies, paroxetine was statistically significant versus placebo, whereas for Saredutant it wasn't statistically significant versus placebo.

Nevertheless, when you've made analysis of the four studies, you see high positivity. An interesting thing is not one single study showed that this product was worse than placebo.

Now, when it comes to benefits, we did a scale to measure sexual function, CSFQ total score. Versus placebo, here, paroxetine doesn't show activity, and we thought it made sense not to show the activity versus paroxetine for sexual dysfunction. But you can see, versus placebo, meta-analysis, positive activity versus placebo, so you can imagine the activity versus paroxetine, which does cause sexual function problems.

Another advantage with this product, perfect tolerance. Look at the figure, as you can see, aside a slight dry mouth, Saredutant tolerance profile really is almost always comparable to placebo or even better than placebo.

It's like in oncology, when you're looking for combination treatment, it's important to have products that are tolerated very well since side effects can add up. It's an important criterion. You have to have good tolerance.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

So this is really quite impressive, here. Tolerance is identical to placebo and sometimes better than placebo. The program's under way. We're just waiting for some long-term tolerance studies. That's why I was just [inaudible] I expected a slide that didn't come up.

Amibegron. This is a very interesting one, amibegron. This is a highly selective agent of the Beta3 human receptor, which was cloned once when the product was being developed. The effects here are both on anxiety and mood. Very good in animals. Very good effect in animals.

In humans, I'll show you a slide that we've already shown. Specific activity in some areas of the brain which were depressed in bipolar patients. We've also got results in patients that are highly depressed -- highly depressed people that are in hospital for melancholia.

We've also got also absence of problems and no metabolism problems. This is important if you're going to be using two products jointly. You have to make sure that these products don't have negative influences on each other.

Now, action mechanisms. [The effects] for Acomplia with Beta3, we're continuing to discover this as we develop. Now, there's no recapturing of serotonin in the synapse, but we have seen potential activity of serotonin with this product. It's in the frontal area, near the corpus callosum. If you see -- it's an area that's depressed among bipolar patients. Towards the top, in the picture here -- sorry I can't use a pointer here, but you can see, this activates the particular area that's depressed.

Now, we showed you some findings earlier that are really spectacular in a severe group of patients, people who are hospitalized for depression. Among some patients, they were stabilized, became almost normal. This isn't the word I'm looking for, I shouldn't say normalized, but bringing their Ham-D under eight. In some cases of Amibegron versus fluoxetine, we had some remarkable outcomes, statistically significant versus placebo in phase III.

There's a slight -- in all patients, similar to paroxetine, in severe patients a little bit -- slight increase in activity. Another survey was done that is not statistically significant. The difference with saredutant [inaudible] significant here, paroxetine, the comparative element wasn't statistically significant either in phased studies, in managed experience. We get the impression that we're getting a better control of developing [groups] for depression in selecting the right patient centers.

Now, tolerance profile's very good here as well. A little bit less good if you look in terms of NK2. A little bit more nausea and a little bit more headaches. But certainly very different compared to paroxetine. In the very near future, we'll have two results for depression and efficacy. These are two studies that, if they're positive, well, we think we'll file some time 2007, 2008.

Insomnia. On to insomnia. I think it's interesting -- sorry to be giving lessons on sleep and how sleep evolves with age, but on the left-hand axis, you have the time of sleep. On the bottom, horizontally, you have the person's age. So what happens as people age?

Sleep time goes down. We start from the bottom here. Stage one, this is preliminary sleep, pre -- early sleep. [Inaudible] graphics here. Stage one sleep, that's just before sleep, it remains. Stage two also remains pretty much unchanged as we age, but the next two stages, stages three and four, slow wave sleep and REM, go down over time.

And et this is the most important component in sleep for a couple of reasons. First of all, because it's felt that SWS has an impact on memory. Also, the second reason it's important to sleep, it's felt that slow-wave sleep is very restorative. When you're tired, you need time to restore and it's this part of sleep that helps you feel better the next day. The slow-wave sleep helps you recover.

Now, there's a third part, the rapid eye movement, REM, sleep. Now, REM, people wondered what rapid eye movement sleep was important for. It's felt that it has an impact on mood, so REM sleep's important when it comes to mood.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

If you're looking at treatment for older patients, to treat insomnia, what are you going to try to do? You want to look for a product that isn't necessarily going to cause sleep, because often they don't have a problem with sleep [latency]. Older patient often don't have problems getting to sleep.

But what you do want to find is a product which will reduce WASO. WASO is awakenings after sleep - the number of times you awaken after falling sleep. So you don't need something to induce sleep. You want to reduce WASO. You don't want to have an impact on REM, REM doesn't change too much with age, but we do want to try to increase stages three and four. By definition, an increase in total amount of sleep will reduce stages one and two.

This is what we've been working on. I won't go through all the results as they were already shown to you by Gerard last year, but eplivanserin, phase IIb, did meet the various criteria.

Now, another point that's very interesting for the time being in insomnia we were just treating people during the night. In other words basically people would have to fall asleep quickly and you would then study them during the night. But now, with the new type of treatment, you work on the quality of sleep. They're not just looking at the nighttime, they're looking at things that take place during the day as well. In other words, you look at the impact a good night's sleep has on a person's daytime activity. The FDA will be validating these scales.

To my knowledge, this was the first time we were able to show a correlation for both products, which just goes to show there's a sound mechanism involved here. We were able to correlate sleep, the product [efficacy] during the night, its impact on sleep, and the quality of people's wakefulness the next day, during the day, and their alertness.

Now, focus on the graphics, this is compulsory. We looked at this on quality of sleep, the patients report on the quality of their sleep. We see the number of awakenings during the night and we also had them report to us on how alert they are the next day.

Now, for the time being, hypnotics were focusing on the nighttime. But with this type of product, we're actually talking about the daytime stage as well. We're looking at the impact during the day.

Then, there's a third stage of this booster [inaudible], and this is what Pierre was showing us. If sleep disorder increases as part of diabetes and morbidity, we have to look in our studies in particular groups, the impact during the night, reducing awakenings in the night. And with the impact on people's wakefulness, alertness and memory as well. And then what takes place in terms of morbidity. This is where volinanserin is positioned.

Alzheimer's. I'll run through this fairly quickly. Just a reminder, xaliproden, three activities here. First of all, we didn't think it was possible, but it's a product that actually makes the neurons grow again using stem cells. It's a product that prevents an attack on neurons, when it's given preventatively. It's also a product which is able to heal or, at least, regenerate neurons after attack.

Two phase III studies have been completed now. We're awaiting the findings in the very near future.

One brief point. The interesting thing here, we're looking at the standard parameter, [metas-cog], cognitive function. We also have a lot of documentation on hippocamp size. A problem with Alzheimer's -- hippocampal volume. One problem is there's no [serogatine] point. The more we work on this pathology, the more we learn about this pathology and the easier it'll become to find new treatments. One of the problems here, it's almost impossible to do a dose effect, which is to treat patients for more than 18 months.

Teriflunomide, now. We're midway through the first phase III study. We have positive results in phase IIb. A second study phase III has just begun. We'll be starting combination studies midway through this year, second part of the year.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Dianicline. Dianicline, to simplify, is like varenicline, you know varenicline, so we can be brief on this. But the interesting thing here, it helps people to stop smoking. Also, it can be used through user therapy. Here rimonabant demonstrated a moderate but effect nonetheless on smoking cessation.

The other advantage with rimonabant, it showed us that by taking -- when you took it, you could avoid weight gain when you stopped smoking. And weight gain is one of the reasons people don't stop smoking, particularly this is the case among working women.

So there is a phase III program underway on dianicline, also a phase I program where we're using -- combining with -- dianicline combined with rimonabant. We think we'll move into phase III quickly and almost market [mono] therapy dianicline and combination therapy dianicline and rimonabant very quickly. It won't be the same administration. The dianicline is active if taken twice daily.

Then two other products -- sorry, there's a mistake, apparently, here. Paliroden, awaiting results for Parkinson's. Rimonabant, Gerard gave you the results last year for obesity, that had shown an identical activity for obesity but less of an efficacy on associated parameters, less on glycemia and HDL, but thought there might be greater activity for CNS.

One of the qualities, plus points of rimonabant is predominant peripheral activity. We are in phase IIB for smoking cessation, [inaudible] phase IIB as you've seen for obesity and related disorders. We've started phase IIa as well since it was a potential CB antagonist for cognitive elements.

In a nutshell, I think we've got an innovative approach for CNS. The central nervous system, it's certainly one of the areas where you have a great need for medicine, for anxiety, depression. We've got Saredutant, Amibegron and more difficult to treat and prevent Alzheimer's. And when it comes to sleep maintenance, we are continuing to explore our franchise here and develop that, extend it and build on our experience here.

27 products for the Central Nervous System, including 19 in clinical development, 10 in phase IIB and III. Pretty reassuring because for a long time about 50% of our R&D efforts remained here. And it's interesting to see now that those R&D efforts are panning out. They can seem unpredictable, but in the long run they usually pan out.

Very quickly, internal medicine. These are much smaller markets. And if you look at all the other products we've talked to you about up until now, we have just [one more to talk about], Icatibant, a bradykinin B2 receptor antagonist. This is effective at relieving pain and side effects of knee osteoarthritis. I'll run through this fairly quickly after which you can come back to this and read through it at your leisure.

What is the potential market for this type of product? We've given you the number of injections here, with corticosteroids making up 80% of the injections, or with hyaluronic acid.

Now the OA, osteoarthritis of the knee is something that's increasing with age. We know that we're seeing more and more of this type of disease among aged -- older patients.

Now the characteristic of Icatibant compared to steroids, first of all. Now this product is quicker acting. The problem with steroids is they tend to take time to become active. Here activity is a lot faster. But, compared to hyaluronic acid, it's quicker acting, but only very short acting. Here we have quick action plus extended action with Icatibant.

Turning to the next slide we've got currently phase IIB studies underway. And the interesting thing is that we've got some IIB studies underway versus steroid. Before beginning phase III, we'll know the positioning of the product, and that is a product we've already talked to you about, the recent [Icatibant] beta antagonist. They are sort of looking for their position right now for treating cirrhotic ascites.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

That's a real advantage for the patient. Ascites are debilitating. No dose effect here we can see, but we do have a product effect in terms of the number of paracenteses, 30% reduction in the number of paracenteses. This means hospitalization and risk of infection whenever there's paracentesis. So there's a very small market. Nevertheless this is a very important development. This medication will be a plus for patients.

There you have it, [inaudible]. Yes this is included in the product that are to resubmitted, resubmission for filing in the United States. It should take place in the first half of this year. And the other product we're waiting results here, antagonist receptor NK1, which we'll see somewhere near in the future.

Pierre Chancel - Sanofi-Aventis - Head of Global Marketing

[Interpreted]. Last but not least is the whole area of oncology, cancer. On this first slide is the second most important cause of death in the U.S., 50% of all deaths among woman aged 45 to 54 in European countries. Every country has its healthcare policies. They're all more and more aggressive anti-cancer programs with the messages.

In terms of cancer everything remains to be done. Approvals have been made, we have data, the pharmaceutical firms are bringing out products, but everything remains to be done. Progress has been made year in, year out, study after study, trial after trial.

Here what I've shown you is the survival rate, the five-year survival rate, by type of cancer depending on whether the tumors are local, regional, that is around the first tumor, or just in terms of metastatic. So the survival rates are dramatic, everything remains to be done.

The second thing is already known. When cancer is diagnosed, in 50% of cases the tumors are either regional or distant. Now regional tumors are when surgery is already out of the question. This is chemotherapy and so on. And of course distant tumors are palliative care.

Now here's the number of the patients. These figures combine the U.S., France, Germany, Italy, Spain, the U.K. and Japan, 300,000 patients every year in lung cancer, over -- nearly 200,000 breast cancer and, of course, the new cases are gastric, metastatic gastric cancer of almost 100,000 a year. Treated with Taxotere. But the number of patients treated is approximately more or less two thirds depending on the type of tumor. Well more or less two thirds of the number of patients are actually diagnosed with cancer.

Well what about us at Sanofi-Aventis? We have committed ourselves to cancer for two reasons. First of all we are the second largest Company in oncology in terms of sales. EUR3b, a little bit more. But also because we have two of the top-five selling cancer drugs Taxotere and Eloxatin.

And we have every reason to continue of course. We've committed ourselves to this fight against cancer and also because year after year, product after product -- we are good improving healthcare, but we have yet to be able to cure cancer. But with the current approaches which are palliative, chemotherapy and targeted treatment, well we are involved in treatment.

And in chemotherapy and the new targeted therapies, new approaches such as immunoconjugates, vaccines or others. Now the products in question are S-1, which Marc has already mentioned, so Larotaxel which is a new taxoid with enhanced indications. As for targeted therapy, VEGF Trap and the AVE8062. VEGF Trap inhibits angiogenesis and the AVE8062 does exactly the opposite, it actually reduces vascularization and it also reduces the tumor.

Now just to begin with S-1, which is a new oral 5-FU derivative, this combines Tegafur with two modulators, metabolic modulators, if I can call them that. Now S-1 is a clear improvement on fluoropyrimidine-based therapies. It has been marketed in Japan since

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

1999 and has been approved in Japan for multiple indications. And, of course, Sanofi-Aventis is leading development worldwide and of course leading sales worldwide, with the exception of Japan and a number of Asian countries. Marc [be] on the floor.

Marc Cluzel - Sanofi-Aventis - Head of Research and Development

[Interpreted]. Now just to complete, or rather to illustrate what Pierre has already said, it would be difficult to complete what he said, and this is Tegafur which is a pro 5-FU. And what are the advantages of these two agents? First of all Gimeracil blocks one form of deterioration of 5-FU. Bearing in mind that this entails what we call hand-foot syndrome, which is a very handicapping neuropathy. It actually prevents people from [apprehending] objects and gripping objects. And this is one of the reasons that this neurotoxicity is very much a handicap.

The other is Oteracil, sorry, which is not present in the bloodstream which prevents 5-FU being transformed in situ in the digestive tract. Now, in situ activation of 5-FU actually entails digestive toxicity such as diarrhea, stomatitis. Here again we're working on product tolerance.

Now if we reduce the deterioration of the product and if we refocus on the active agent, what we're aiming at in doing so would be to increase the anti-tumoral activity. This would also enable us to improve immunotoxicity which is directly related to the anti-tumoral activity.

You see the figures, [inaudible] suppression, [inaudible] is very, very low. The product is itself in fact very well tolerated. Well this product has been marketed in Japan for a number of years now, has been registered for several indications.

We could have given you a complete demonstration of all the results, all the conclusions. But we've just selected what we feel are the most interesting. This is its activity as an S-1 adjuvant. This is for monotherapeutic purposes and not used with [cystatin]. This is for patients who have been operated, and who have theoretically have been cured by the surgical operation, but as you know there is there is also the danger of metastasis.

So the randomized, the stages II and III, depending on the deterioration of the gastric walls and the way they're treated with monotherapy or with surgery alone. And the end point as with most of these adjuvant studies was, of course, survival, bearing in mind that almost always we're looking for five-year survival.

Well, the good news and the good news for [Tayo] as well, [Tayo] is the lab that discovered the molecule, the good news is that the steering committee requested that the study be discontinued after three years in view of the fact that the survival rate was remarkably high and significantly very significant and has recommended that patients operated for gastric stomach surgery should benefit from added treatment with S-1.

On the left-hand side you have the complete survival rate. Ideally it should be cut off after three years, because the number of patients is very different and the same, right, for three-year relapse rate for survival on the right-hand side. In absolute figures the reduction is 10%. So 10% of all the patients on S-1 will out-survive the patients not treated with S-1. Maybe one small step, but it's a big step, and otherwise, very similar to Taxotere, where the improvement was actually 43%. So a very significant improvement.

So as I said this should be taken as a significant step in adjuvant therapy, but it should also be thought of as regards the good tolerance levels. In terms of toxicity, you can see that we expect some degree of neurotoxicity, with a number of -- grade three here on the leukocytes, in particular, leukocytes and hemoglobin. I think the product has already been proven, very low vomiting, diarrhea and very, very low levels of anorexia.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

We haven't experienced any hand-and-foot syndrome, which was also evidence of the fact that the hypothesis can be deemed validated as a total neurosuppression of grades one, two, three and four. You've only grades one to four, and the total for grades one to four was [7%] which is a very reasonable level.

Now, as you know, the study lasted three years. At the same time as the adjuvant study, we conducted a number of other studies to determine the advantage of associating S-1 with other products. And as you know, in oncology there are three potential areas in which we can improve.

The first of these is new chemotherapies, but particularly new chemo associations. The second area we can improve in is the cytostatics, and we have the example with the VGEF Trap of [combastatin]. And the third area is by improving the tolerance of other types of treatment in order to increase the doses.

Well, we found that by associating the cisplatin and S-1 was much more efficient than S-1 alone. So we conducted a phase III study, that's cisplatin versus cisplatin plus S-1, and recruitment should be completed by the end of this year with the submission early next year. The primary endpoint is, of course, survival, overall survival.

So what next? We can look at the 5-FUs. It's a bit like Eloxatin, we have a super Eloxatin. That does not mean that we should venture into all markets where cisplatin has been marketed. In some areas cisplatin has worked very well. But obviously we want to work in all 5-FU areas and the areas where [Xyloidin] is to be found, even though this product has characteristics that give us reason to hope that it will be better than Xyloidin.

Perhaps one of the most interesting domains would be a colon and rectal cancer. It has been successful with Eloxatin, but it is really in colon and rectal cancer that we have our greatest hopes. It is interesting to see the penetration rate in Japan, despite the fact that Xyloidin and S-1 started the use at about the same time in treating colon and rectal cancer. Studies to be launched this year.

The taxoids now. Well, Taxotere, which is the world's number-two out of the three products in oncology, is a highly active product. Two little concerns about it, the one is tolerance. The tolerance level is roughly moderate, which prevents it from being used with other anti-cancer adjuvants. The other problem is the problem of tolerance, it's edema and coloring of the nails.

So we tried to improve Taxotere. So another thing about Taxotere is that resistances have appeared. With repetition, repetitive resistance. As we successors to Taxotere, we have worked in two areas -- two directions. First of all on products that reduce resistance to Taxotere, or at least act on patients that resist to Taxotere, patients that can have cerebral activity and obviously with a view to improving tolerance.

And mixed results for Larotaxel. The first study was very, very encouraging. With Taxotere-resistant patients we found that the response rate was 20%. This led us to believe that this product would have the -- would be very good, so we started a study to compare it with monotherapy, Larotaxel versus capecitabine.

We were disappointed to discover that the response rate was very comparable between Larotaxel and capecitabine, which prevented us registering it for the -- the initial indications hoped to register for which was the Taxotere resistance.

These two studies nonetheless confirmed two things for us. First of all, the activity of our product and secondly the high tolerance level. And this good product tolerance meant that we had been able to work on phase III in association with other agents, mainly in metastasized breast cancer.

Here we have an explanation about the relative positioning of Larotaxel and its small brother, as we say, XRP6258. Larotaxel, well the indication was hoped to be a new adjuvant breast cancer. But before embarking on that we decided to conduct a pilot study on the [emergent] breast cancer through exposure. And if this trial proved to be positive as a [neo-adjuvant] we would run a trial on an adjuvant.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

In view of the good tolerance level of the product and in view of its tolerance profile, we propose to work on combinations. After an initial treatment on breast cancer we decided to combine with capecitabine and trastuzumab. We decided also to work on new indications. This is cancer of the pancreas and the bladder. As for XRP6258, we are already working on phase III of a study in prostate cancer.

Now we are on cytotoxics up to here, but another area I find -- I personally find very, very interesting which is the cytostatics, but particularly vascular cytostatics. And here again we are well positioned. Broadly speaking, everybody knows the approach on the left-hand side which consists in blocking the VEGF activity, the main product being the [plastine], which has proved its survival possibilities in various cancers, and colon and rectal cancer in particular.

VEGF is necessary to ensure that vessels grow, so if you inhibit VEGF then you prevent the vessels from growing, which prevents tumor growth. That's the left-hand side of the chart.

Now moving to the right-hand side, this is something more recent, something that hasn't really been studied, certainly not to this extent. The first part is preventive medicine. You prevent the vessels growing. On the right hand side you do exactly the opposite. You have a tumor, so what you do is, rather than prevent it growing, then you break the vessels. And by breaking the vessels, you kill the tumor.

Now by killing the tumor there is always a risk. These aren't products that can be used for all sorts of cancers. With cancer of the lung there is a danger of perforation. But for more solid cancers and more solid tumors with less risk of perforation, it's certainly a very interesting indication. But we have clinical conclusions for this type of product.

Interestingly with the killing of tumors, if you take in cancer for instance, most of the resistance cells are essentially found at the heart of the tumor. They're very difficult to access by conventional cytotoxic treatment. But if you kill the tumor by preventing the vessels bringing blood and sugar to the tumor, you have a good chance of killing off these core cells that are the most resistant. So you can then consider a combination, either a sequential combination of the VEGF, which probably inhibits metastasis, and the growth of tumors with a product that kills the tumor.

VEGF Traps. So what's the difference with a VEGF blocker? Broadly speaking when you have a receptor -- the human body was put together with bits and pieces, by adding on bits here and there. But with a given receptor, there is very rarely only one active receptor. So the VEGF, if you want to look at it that way, the VEGF activates, but then you have other factors that can activate it such as [inaudible]. So when you have a VEGF antibody the activity is not complete. There a number of other activators that can, other factors that can activate the receptor.

Now the Trap receptor that was, this was a Sanofi-Aventis discovery by the way, we're working with [inaudible] that block the inhibitor. We take a [inaudible] of the receptor, VEGFR1 VEGFR2. We take these two [inaudible] receptors, associate them and inject that. To do that, all products that can attach themselves to VEGFR1 or R2, it's like a vacuum cleaner, if you like. Take all products capable of attaching themselves to the receptors. In vitro events, the activity is higher to VEGF or VEGF antibodies, these are usually the plastines.

Obviously products that can be active in monotherapy, and as [soon] as proved, this is especially with kidney cancer using in conjunction -- combination therapies.

What about VEGF? First of all, let me tell you and give you a progress report. We virtually, well, we were still working on phase I. We've now finished phase I, we're on phase II and III in monotherapy. And we're working on phase I and II combinations, to determine what the best combinations and the sequencing of the products would be.

We'll see what cancers that have to work on. But in terms of safety -- safety and efficiency, of course, go very much hand in hand. If you decrease the doses in some areas this will increase blood pressure so you can't always associate the two. But in a word, we have an excellent benefit risk ratio with VEGF trial.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

So what I'm going to show you here is all single-agent trials, the product on its own. From time to time we have to face up to rumors on the business profile, clinical rumors. We need to put paid to rumors. The rumors of symptomatic ascites was discontinued because of poor toxicity of the product. I can tell you it's the reverse. Excellent product tolerance in the treatment of malignant ascites after ovarian cancer. The program's under way.

And not only, in addition to excellent tolerance, a program underway in the treatment of symptomatic ascites, excellent response. Under treatment all patients thus far have responded to treatment with a mix of complete and partial response [facing] of paracenteses.

And just to keep it simple here, it's also in white, but it's not the same white, it's the visceral fat, you have the liquid on the left-hand side of the page. And both cure under VEGF Trap in single-agent therapies malignant ascites.

Also single-drug therapy in ovarian cancer. Complete response with VEGF Trap. That's the small arrow. You can see that the cancer has diminished over 50%. That's partial response, almost complete response.

And a very, very interesting point, never demonstrated to our knowledge, maybe been done but not published, Avastin has never demonstrated in single-agent therapy efficacy in this broncho-pulmonary cancer. And here you have an example in the single agent therapy for lung cancer.

Here you have both our single-agent development possibilities of registration, be it in symptomatic malignant ascites or ovarian advanced, advanced ovarian cancer and in non-small-cell lung cancer.

And there are further developments that will take a little more time in treating hormone-resistant prostate cancer, for gastric cancer with Taxotere, in non-small-cell lung cancer, and also we had some preliminary responses, excellent associations with FOLFIRI.

So first submissions, a wave of submissions the first planned essentially in 2008. So that was just a recap. It's an interesting product.

Pierre Chancel - Sanofi-Aventis - Head of Global Marketing

[Interpreted]. It's a product that had rather complicated development but thanks to the NAH, we found the right way of administering this product with 43% partial response and so phase II, III underway in chronic lymphocytic leukemia with a submission potential, every likelihood in 2008, ditto for VEGF. The date may vary, but the product will be submitted. It's an excellent product.

Xaliproden, I showed you a first study demonstrating the prevention of neuropathy to increase the dose, better tolerate Eloxatin for patients in adjuvant therapy and to up the product dose for other patients. The phase III is underway. If it's positive, we will file and the first study, this is [mets] cancer here in adjuvant therapy to [in-treat]. If it's better tolerance then patients are treated longer. If they're treated longer, less risk of relapse.

Just a nod because we're presenting vaccines and pharmacy, so just to say that we're working together. We also work elsewhere other than here. But it's really on developing a cancer vaccine. We're working jointly on the melanoma. There are studies about to get underway. And also, colorectal cancer and we -- this is in, of course, short term but we believe that say, five, 10 years down the road, there are some interesting opportunities in immuno-stimulation by other mechanisms. Antigen discovery.

I think I've reviewed all the phase IIB and III products.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Oncology, we're strengthening our leadership position in the field of cytotoxic agents, thanks to S-1 and the new taxoids, to improve this therapeutic approach. And Xaliproden to reduce platinum-based chemotherapy toxicity. And what's new is that we're now moving into cytostatics that you'll hear more about. The 8261, it's an excellent opportunity between an inhibitor of vessel neogenesis and another that destroys [inaudible].

Thank you, for both of us.

Unidentified Company Representative

[Interpreted] Thank you, Pierre.

Gerard Le Fur - Sanofi-Aventis - CEO

[Interpreted]. Well, it was rather long. Forgive us for that. I'll attempt to keep it short.

Since its formation over 34 years ago by Rene Sautier and Jean-Francois Dehecq, this Company does not need to demonstrate its ability to adapt. And I believe that this year, 2006, in a difficult environment, Sanofi-Aventis has clearly demonstrated its ability to adapt. And we owe this to the combined efforts of all our staff and this needs to be commended.

Ability to capitalize both on our Base Business and develop our major products. Let me remind you that Hanspeter showed you that we have eight blockbusters. By that I mean that we have eight products whose sales is topping the EUR1b mark. Four in cardiometabolic, Lovenox, Plavix, Aprovel, Lantus, two in oncology, Taxotere, Eloxatin, and two in CNS, Ambien and Copaxone. I'm not sure that many other companies have eight blockbusters.

Secondly, ability to capitalize on our Base Business. Hanspeter has shown you that both in Europe and in the U.S., we have managed to slow the decline in sales of our Base Business, but in the rest of the world, we have managed to increase by 4% the sales of base business.

When Jean-Francois, at the time of the acquisition of Aventis, said that no products, no small countries, 2006 is directly in line with that statement. We are present in therapeutic areas that are posting high growth, meeting all needs -- medical needs for thrombosis, cardiology, diabetes, oncology and vaccines.

We are convinced that in the years to come, given the very significant increase in healthcare costs, we must offer governments a comprehensive proposal, both innovative medicines, the Pharma approach and vaccines. And let's not forget here a targeted approach of generics manufacturers. Look at what we did with Zentiva in the East and a novel OTC approach in certain products in the rest of the world.

A strong and dynamic presence in geographic areas that are growing strongly. Here again, no small products, no small countries, and we are growing strongly in the BRIC countries. We are growing strongly in these high-growth emerging markets, keeping an eye on our expenditure, where spending is contracting. But where the market is growing we invest heavily and it is linked to this geographic presence that is very important for the company.

Lastly, and I was going to, for historical reasons, there has always been sustained R&D spend targeted on innovative fields and compounds.

On this slide, on the left-hand side, you can see that the top-five therapeutic classes hosting the highest growth rates are, of course, therapeutic classes that are our core business. On the right-hand side, here again, vaccines have posted 10 years of constant growth. And what Wayne showed you earlier, quite remarkable results. Over 22% increase in Sanofi Pasteur clearly illustrates the interest and the importance of having a significant presence in vaccines.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

We are focusing on R&D efforts to meet major healthcare needs and there's no need to convince anyone when it comes to underscoring the fact that cardiovascular disease and cancers are responsible for both a significant share of death and disability. But we tend to forget also that mental illness can be a killer illness and induces a high level of disability, and we therefore must expend considerable efforts in this field.

And let's not delude ourselves. We know that it's a very difficult area where the attrition rate is high but it is, indeed, necessary to invest heavily in this field. And let me remind you what Marc showed you. That is, we have a relatively high number of products in the pipeline for mental illness.

We are deploying a significant R&D effort. Sales is only increasing by 4%. We are upping R&D expenses by 9.5% thanks to a stepping up of phase III clinical trials in Pharma. These efforts are even more significant in terms of vaccines, be it to accelerate the clinical trials of these vaccines, but also significant investment in discovery. And the prime take-home message regarding R&D for this meeting is that today we have 46 clinical trials in phase IIB versus only 35 a year ago.

2006, in a particularly difficult climate, once again we have been able to deliver good growth. We have adapted our resources swiftly when it comes to reducing our expenses and invest selectively. Where we needed to invest, we invested heavily.

We've reduced costs in France and Germany in response to tighter healthcare cost containment measures. In both these countries we have reduced costs in the United States in response to the Plavix situation and the generification of a few products whilst continuing to support Ambien and Lantus and preparing for the launch of Acomplia.

As we have told you, we have invested heavily in high-growth countries. This is the case in particular with the BRIC countries, and we've continued to invest heavily in R&D. We therefore maintain our EPS growth. And this is a remarkable achievement in the Pharma industry.

I don't believe that a company that has suffered a generification of four products in the U.S., that suffered the launch at risk of clopidogrel in the United States. When a Pharma company suffers this, at best it is break-even in terms of EPS or even negative. We posted a growth of 10.3% excluding exceptionals, 5.9%.

That clearly is an illustration of this -- the strong adaptability of this company. Of course we are a big Pharma with its clout but, for historical reasons, we have preserved this modularity. We are therefore capable of reacting -- responding rapidly when small problems occur, which is unfortunately, today, the day-to-day business of Pharma industry as a whole.

2007 will be a key year. We've seen that with Lovenox. We have lost the suit for inequitable conduct. We will strongly defend this patent and we will appeal. Secondly, let me remind you that, to my knowledge, and when I say to my knowledge, it's that no company, no agreement, no [NDA] has been delivered by the FDA.

Lovenox is a complex product. Oligosaccharides from a pork intestine, very complicated to replicate at industrial scale and this is not something that is easy to produce. Secondly, let us remind you that Lovenox in the United States is a rather special distribution because it is essentially in hospitals. So, for all these reasons, we remain optimistic on Lovenox.

The Plavix suit, as you know, the hearing started on January 22. Let me remind you that since the launch at-risk of Apotex in August we've made headway in the right direction. We have attained the preliminary injunction that we won the appeal and that in Canada, where we won the suit, we also won the appeal. So, for these reasons, we remain very optimistic regarding events around the Plavix suit.

Rimonabant in the U.S., here again, this is very, very important. You saw that last night we issued a press release because the FDA extended by three months the action date and that we filed the SERENADE study. That is the study that Marc described, in diabetic patients in single-drug therapy.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

On Rimonabant, I would like to tell you that it is certainly not a cosmetic lifestyle product. It is not for American big bottoms. It is a product for visceral obesity, and Marc showed you some key results in this Japanese study. By CT scan, for the first time, we were able to measure the effect of this product on visceral fat and you can see that it has selective and principle action on this visceral fat as compared to subcutaneous fat.

And with this effect it clearly demonstrated, is underpinned by a number of theoretical studies, demonstrating that the endocannabinoid system present in visceral fat doesn't work in the same way as the endocannabinoid system present in subcutaneous fat. So there's the theoretical basis for this.

And there's also something that is crucially important. It's the results of the SERENADE study because in severe diabetic patients, HB1C above 8.5%, Rimonabant induces a reduction of this HB1C of the order of 2%, and that can be compared to any anti-diabetic that is already active. And this single-drug therapy follows up the RIO diabetic study where the product demonstrated either in association with metformin and sulfonylurea, great potentialization of the effect on insulin resistance.

I'm telling you all this because for historical reasons we presented Rimonabant, firstly the RIO lipid study and the RIO Europe and U.S. studies as a product that reduces weight and acts on core morbidities, be they lipidic or diabetic in origin. Let's assume that we present today the Rimonabant profile. Well, we could tell you that it's an anti-diabetic product, active in single-drug therapy, notably very active in severe patients, active in association with the oral anti-diabetic products such as metformin and sulfonylurea.

And, in addition, it has a beneficial effect on good cholesterol, increases HDL, reduces triglycerides and, what is the case for very few anti-diabetic products, this product reduces weight. By that I mean that clearly and finally it is certainly not a lifestyle product. And choose the way in which you want to present it, but we are convinced, and that is why we have a life-cycle management that is as [onerous], that these patients with a high cardiometabolic risk need a product as sophisticated as Rimonabant. And the morbid-mortality CRESCENDO study which will run for five years will demonstrate, I hope, the advantage of this cardiovascular prevention of such a mechanism.

[Inaudible] and finally, 2007 is an important year because as you will have understood with Pierre and Marc as a duo of outstanding performers, we'll be seeing a significant flow of phase III results all through the year. And this is what makes us so very optimistic. We're not naive and we do not believe by any means that all of the outcomes will be positive. However, we know that when we get into phase IIB or phase III, that there will inevitably be some successes.

And perhaps I could add, in terms of the historical development of R&D, we have very often been asked to organize an R&D day that would be devoted to R&D. Well we haven't done that yet. But now that we are through with the merger, and the system has been stabilized, as Marc mentioned, in September next, we will be organizing a research and development day at which of course we'll present the results for advanced products.

But we'll also be giving you much more information about the upstream component. And this will provide you with a much better understanding of our strategy. And perhaps in so doing we will be showing the kinds of transparency which I have heard we have sometimes been accused of not showing. And we feel very much committed to transparency so we will be very happy to be doing this.

2007 then will be another year of earnings growth. You know that the Ambien IR will be coming to the end of protection in the United States. This will come about in April. However, Ambien CR will continue to be protected. We have tremendous ambitions for this drug.

It's highly sophisticated. I would suggest trying it, comparing it with Ambien IR. I did so myself and let me tell you that you really do see the difference in terms of the duration of sleep, the way -- how long it takes to fall asleep and the fact that there is no remnant sleepiness effect.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

We hope to be able to defend ourselves with ready-to-use forms of other forms of the drug that we have been working on with all of Sanofi-Aventis mobilized to deliver an adjusted EPS growth, as we put it, excluding selected items in the same order of magnitude as 2006 growth, barring major adverse events, including events on Lovenox and Plavix in the United States. We expect to see a growth in our sales on the same lines as in 2006.

And having said all that, we will now be very happy to answer any questions you may have. With a little more light in the room, we'll be able to see the people asking the questions better. That's it.

QUESTIONS AND ANSWERS

Sebastien Berthon - *Exane BNP Paribas - Analyst*

[Interpreted]. Sebastien Berthon of BNP Paribas. A few questions. First of all about Acomplia. Could you tell me what the main reason is for the supplementary review issued by the FDA.

And secondly, how is the recruitment for the CRESCENDO study going?

When it comes to saredutant what are the next stages? Is it simply going to be developed for anxiety treatment or do you still foresee further studies on depression?

When it comes to the VEGF trap, are you considering clinical head-to-head study against Avastin?

And to end my list of questions for this time, when it comes to [inaudible] is there any chance that we will see the results of the [ATHENA] study before the final results are out?

Unidentified Company Representative

[Interpreted]. Well Marc, I think you're on this one.

Marc Cluzel - *Sanofi-Aventis - Head of Research and Development*

[Interpreted]. Well, when it comes to Acomplia, we decided long since not to make any comments on FDA decisions, but there are two points. A, there will be a three-month extension of the date. And then secondly we always have a permanent rolling-up date. Well, in Europe it's not permanent, either every four months or every six month. But [inaudible] have permanent updates on the safety of the product. In this case, it's the efficacy, which is what we're looking at.

Well, turning to Acomplia results, I think no one has any doubts as to its efficacy. When it comes to tolerance to this drug, in Europe we have seen no particular tolerance signals aside from the elements which were in the initial file. I think that's important to underline. So for the time being, we're simply waiting for registration in the United States. And this will come about sooner or later, hopefully in the course of this year.

Moving on to the second drug you mentioned, cardiologists are somewhat surprised by the excellent tolerance level in terms of CRESCENDO study, because cardiologists aren't always used to working with such good tolerance of drugs. The problem is that when it comes to recruitment, we tried to define the targeted population based on an events ratio, which is a little low, so we're trying to move it up.

Moving on to VEGF trap, there are two possibilities. One is to move into realms like pancreas cancer where Avastin is not active, another where Avastin has not proved successful, for instance, colorectal cancer. And then the third possibility is that to use all

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

other avenues. And we'll be keeping all three avenues open. On the last one that you mentioned but we probably are pretty much within the goalposts in terms of recruitment for this study and hopefully this will remain the case.

I was going to forget saredutant. Depression is a new application that we are presenting a new therapeutic class, which is not always tolerance data, possible associations with amibegron. Also, we are looking at other potential agents used in combination.

Just a brief additional point regarding Acomplia. Of course we do not comment, nor will we ever comment FDA decisions. We would, however, like to point out that in recent times there have been several instances where new application -- authorization demands have been extended by three-month periods. Needless to say, we are extremely optimistic as to obtaining an NDA for Rimonabant. Sir?

Unidentified Audience member

Just four questions. Firstly in Japan, before the data at ASH, the benefit [inaudible] maybe more questionable. [Inaudible] a sense of [inaudible] and we [inaudible].

Sorry. Is that better?

And the first question on idraparinux. Both [inaudible] wants to help reduce the longevity of the drug in the body. Then, my question is how you're going to position [inaudible] good future for the normal version of the [inaudible] ASH. First question.

Second question is regarding Plavix. My understanding is that you negotiated process contracts regarding Plavix to maintain some market share during [inaudible] from Apotex. How much price difference did you put in when [inaudible] and where we see price going forward in Plavix [inaudible] ban the drug?

And thirdly on Acomplia. You showed a slide on Acomplia and it's use in hypertension. First type of data you've seen doesn't seem to have any benefit on hypertension clearly through the visceral mode, I can see why that is. The question is, how many patients have sole hypertension that are using Acomplia U.K. and in Germany from the data you showed, as opposed to combination therapy for dyslipidemia?

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

I'll start with the Plavix question to give my friend some time to see the scientific. You must understand, I cannot give you precise information to which extent either [inaudible] and Bristol-Meyers has been obliged to make concessions concerning commercial conditions. I have to remain vague, but I have to be clear that we will not to back to the previous price system because it has been harmed by the appearance of this [inaudible] generic. But I cannot go more into detail.

Unidentified Company Representative

So for idraparinux, [inaudible] when presenting the number of products in order to say that idraparinux [inaudible] as one product. So, so far, we still do not know because we developed and have a product to be submitted. With idraparinux, we did [inaudible] did not know that if idraparinux studies are positive, it is likely that we will not get at least only biotinylated idraparinux because we've seen that it is a definite disadvantage. It doesn't solve a number of patent protection.

For the hypertension, there is not clearly a potential with rimonabant. But what is -- we have an effect on weight and it is well known that an increase of weight is increasing the blood pressure. So in fact we have, by effect on weight, an indirect effect on increased blood pressure. But we do not have -- so we are not [inaudible] creating hypotension with rimonabant.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

It was an indirect effect and it was interesting also to ask because we have always said that we are [inaudible] cardiovascular risk factor so one which is derivative, the other one which is good cholesterol, or increasing good cholesterol, HDL, which is a direct effect and a third indirect effect which is by the way reducing the weight which will also reduce the increase the increased blood pressure.

Graham Parry - *Merrill Lynch - Analyst*

It's Graham Parry from Merrill Lynch. First question on your guidance. After a good year in 2006 with good cost reductions, it appears your conservative -- your guidance for 2007 is somewhat conservative. I am just wondering what you are assuming in terms of generic Plavix for that 2007 guidance.

And, secondly, on a reported EPS basis, I was wondering if you could steer us to anymore restructuring charges or write downs that you are aware of that you may have to take in 2007.

And then a question on Acomplia, can you just clarify that the SERENADE data filing is the only reason for the delay at the FDA and that you haven't had to submit any additional safety data along with the SERENADE data?

And then, finally, if you could just confirm [inaudible] perhaps could you just confirm are there any head-to-head studies versus Avastin in Europe for the VGAF Trap phase III program? Thank you.

Unidentified Company Representative

I can take Acomplia. You know again we are not commenting on the decision. I just can say that it is not because we need to add more safety data [technical difficulty].

I said again, we still do not know if will go head to head versus Avastin or if we will go in [inaudible] is negative or where Avastin was visually active and is more active. So, again, it will depend. So far we have the potential to be [inaudible] active. But that's a question [inaudible].

Graham Parry - *Merrill Lynch - Analyst*

And actually a follow up on Acomplia. Can you just confirm that you have actually requested a full diabetes treatment label with the SERENADE data?

Unidentified Company Representative

It is interesting but you know that it is at the end of the process. [inaudible].

Unidentified Company Representative

One more time, we are sorry, but we will not comment when we are in relationship with the authorities. This is our policy. As you know the FDA doesn't like too much that we comment a lot or what they are currently doing.

Graham Parry - *Merrill Lynch - Analyst*

And then the question on the guidance.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Company Representative

I believe if I understand your question correctly, you expect the guidance on the sales of Plavix in the United States? Is this --?

Graham Parry - Merrill Lynch - Analyst

It's what assumptions are you making for the penetration of the generic, how many months more inventory are you assuming in your guidance that there is to wash out?

Unidentified Company Representative

I can only repeat what I tried to say before, that we see as of today is that stock of the generics for the major --three major wholesalers seems to be exhausted. We still see stock which we had in demand for the original from the mail order houses and from the retail.

Coming from this, we believe that will take until the end of the second quarter 2007 that all generic stock will be exhausted in all trade channels at the worst. I have to leave it to you. I think we have not much more information than what I give you.

And the rest, to a certain extent, is guessing. We have indicated from the very first day of [inaudible] as a generic that Apotex has obliged its trade patents to secrecy agreements not with report on their stock. And so we continue to try a little bit in [inaudible], but on the most important side, which means the major wholesalers who have clones, we know that this is a crisis because we have incoming orders in the usual magnitude.

Unidentified Company Representative

[Interpreted]. Perhaps I could reformulate this in a slightly different way. We, you were saying that if Apotex had delivered enough to satisfy all market need until the end of 2006. now, as it turned out, not all the people concerned were delivered on the same terms. That is why we had some, for instance, the wholesalers come back to us [inaudible] \$25m from August 8 to December 31.

Now, if we assume that the starting assumption was not totally absurd, well, could you agree [inaudible] third quarter -- first part of this year. And it's not a matter of no sales in the first quarter and we'll see some sales in the second. Well, you will have a very difficult picture depending on which wholesaler you are looking at. But broadly speaking, I think the key point is our starting assumption was not totally absurd.

So what we would actually be using would be something to the tune of, don't quote me on this, say \$425m, which we would otherwise have earned in 2007 based on the normal rhythm of the product and building up increasing speed.

Unidentified Audience member

[Interpreted]. This is [inaudible]. I've got a question on restructuring efforts which you began in 2006. We hear a lot about industrial efforts being made among competitors. Could you talk to us about this? What have you been doing since the merger with Aventis? What might we expect in 2007 on these points and also what are you expecting for the cost cutting?

Then a more timely question, Eloxatin. We saw some weak growth in the U.S. for Eloxatin. Should we expect that will change? Will Eloxatin begin to stabilize in terms of its growth in the United States? In Europe, the period 2007 will be somewhat difficult. Thank you.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Company Representative

[Interpreted]. Let me begin with Eloxatin. Eloxatin in the United States. We have to remember two things here. First of all, penetration, the first classic indication, colon cancer. Such great penetration already for that indication, but I don't have much hope to see more than maybe growth of around 5%.

Apart from that, the second element to remember, other indications, including head and neck and gastric. Here we are just at the beginning, therefore, well in our budget between five and 10 for the U.S. where the product is still protected as opposed to its situation in Europe.

To answer on the industrial point, in the last two years, there was double-digit growth. Now it is single-digit. That having been said, and I think if I understood what you are referring to, that having been said, we are absolutely not going to start doing some major industrial restructuring as is the corporation you are alluding to.

No, we are just adapting. In no case are we talking about some major upheaval, no major changes in terms of production and facilities. Yes, Ketek has gone down quite a bit, therefore, we have adapted the Ketek facilities, brought this in line with our requirements. However, we are not beginning any large-scale restructuring of our production facilities.

Philip Brennan - IXIS Securities - Analyst

[Interpreted]. [Philip Brennan], IXIS Securities. Over here. One question first of all on the 12 products for filing in 2007, 2008. Which ones are likely to be filed in 2007? Most of them are for 2008. But which of the 12, in your opinion, potentially may be block busters?

Another question on [terefluinamide]. You talked about a second study. Will that be a European study? Can you tell us what your registration strategy is for that product in the United States?

Unidentified Company Representative

[Interpreted]. [Terefluinamide]. First study was European, the second one will be the rest of the world, including the United States.

Regarding filings, to be fairly brief. The first wave will be toward the end of the year, CNS. Next year mainly oncology. Idraparinux, 2008, dronedarone 2008, of course. Potential block busters, dronedarone, yes. Idraparinux, yes. Depression will be conservative. The one out of two but the potential [inaudible] can be brought in. At risk, but if it works, yes.

Sleep, insomnia, some examples will be difficult but we could have a block buster, yes. S-1, probably difficult to understand. They're very good results for oncology, rectal cancer. VEGF, we'll see, combined with Avastin. [Egotiban], at the current stage, no. That's basically it, I think, it covers the points.

Philip Brennan - IXIS Securities - Analyst

[Interpreted]. Now this question, idraparinux. Idraparinux, could you compare. The market is full of things. There are oral products by Bayer, BMS, Behring. Don't you think with it's potential because there are a lot of players in the field?

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Company Representative

[Interpreted]. Well it's not the market for the time being that's crowded. Its development that's crowded. Products are to be marketed, then we will see how crowded things are. Like I said to you idraparinux has the profile that is somewhat unusual, real advantages. You know there is no drug interaction. You don't need any monitoring. You've got an injection once weekly. I'm not saying we will take over the whole market place but it will pick up a good bit of the marketplace. But hopefully we'll take a bit of the marketplace.

Look at Amadeus to be presented to the FDA in July. Efficacy profile compared to vitamin K is very good so some intracerebral hemorrhaging which caused us shutdown of the study but that has been dealt with. So we do think this product is industry competitive. Don't forget this is an area where we are starting to get experienced which why I say there's crowded development but the market is not crowded. That is something else again.

Go ahead.

Unidentified Audience member

[Inaudible]. First of all could you give us an update on the Menactra supply please? How many doses you intend to ship in 2007? And you've always guided that the price would go up significantly in 2008. Will it go up in time for the European launch and so the total for the 2 to 10 indications, and will you have full supply for 2008 and should we look at full capacity more for something like 2009?

And the second question on vaccines, I know the legal recommendation [inaudible] universal access vaccinations. The question is whether the public will embrace it. Can you review the 2006/7 season regards, have all the available doses been shipped and, more importantly, what effect do you get when the markets have all been really administered or are there going to be some returned?

In terms of pharma, it is all very interesting on biotinylated idraparinux that you try to base study [arterial fibrillation]. In any case that would assume that given that you have an antidote. Recruiting should be a lot less difficult if you do another, because of the risk that the patient, elected risk. So how quickly do you think should you actually do a study that starts this year? Do you think you will have data by 2010?

And then a question to [inaudible] on the VEGF Trap. First the business 2008. I assume that must be for the phase II single-arm study so its probably malignant ascites or ovarian cancer. So can we conclude from the fact that you do not yet know [inaudible] Avastin several phase III studies which you've announced, the protocols haven't been finalized yet?

Oh, and then a final question. Given that the top line this year has probably been negatively impacted by the generic Ambien, should we assume the percentage of sales is going to go up this year?

Wayne Pisano - Sanofi-Aventis - SVP, Corporate Commercial Operations

Okay, in terms of Menactra, we delivered 4.2m doses into the market place in 2006. We will have 7m doses available in 2007 which will more than meet the demand out of the U.S. and Canada. This will go up to 8m doses in 2008 and then in the 2009, 2010 timeframe we will have the new facility online which basically removes any constraint whatsoever and allows us then to seek licensure in the E.U. and the international zone.

In terms of the flu marketplace, 2006 was an unusual season, or maybe more typical in the U.S. because of the last four years of supply constraint, but there was delays from the other two competitors, in particular, in delivering vaccine. One was tied into

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

the licensure of a new facility in Canada and that resulted in shipments beginning in October, which was rather late. And the other competitor basically did not ship doses until the beginning of November, which is very late for immunization.

For that reason and, by the way, we delivered 52m doses, almost 50m doses by the end of October. Right now there appear to be excess supply, particularly from one of the competitors who was delivering doses in the December timeframe. That said, the ACIP is I think now is confident with three major manufacturers that they can become more ambitious and aggressive moving toward immunization for healthy adults, and we will be partnering actually with the American Lung Association to drive toward this universal immunization.

Unidentified Company Representative

Okay, for idraparinux biotinylated, you know you can [inaudible] fact, [inaudible] recruitment. You can play on the simple size because you expect a better effect with idraparinux. That was our original [inaudible] -- that was our original expectation.

You can turn a specific population to increase the event rate and so I think we will play a little bit on [inaudible] of it. I cannot promise that it will be fully -- that we will deliver in 2010 which will be not so far from that.

And VEGF, I pick up the first part, I agree with you that the first indication will be monotherapy. I did not pick up the second part of the question.

Unidentified Audience member

Have the protocols been finalized? Should we conclude that if protocols have been finalized for those sides of the phase III studies which you highlighted you are going to start?

Unidentified Company Representative

We are starting now. They are finalized, yes. We are starting the phase III now.

Unidentified Audience member

Okay, so that would be then additional studies where you would go through against Avastin?

Unidentified Company Representative

Clearly.

Unidentified Audience member

Okay, thank you.

Unidentified Company Representative

And in terms of the last question which was a mix of Ambien and [RD]. So the treatment [inaudible].

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Company Representative

Use the microphone please.

Unidentified Audience member

So obviously you are not guiding for top-line growth. I'm not asking for one, but we should -- it's probably not huge given that there is some negative impact from generic Ambien. So, given that the top-line growth is probably like lower single digits, should we assume that the R&D ratio as percentage of sales goes up this year?

Unidentified Company Representative

[Interpreted]. I'm not entirely convinced that digits for R&D, to compare R&D spending on sales, it is important to look at that. This year to my knowledge we increased by 0.8%, 1% more or 1% less, I don't think is a major factor which is why we don't give guidance on that.

Unidentified Audience member

[Interpreted]. I have a question. In the press they were saying that you are now preparing to merge with your U.S. partner, BMS. First question, generally, are you considering that type of transaction with a strategic option. Secondly, are you preparing that particular project?

Unidentified Company Representative

[Interpreted]. To be crystal clear, I have already said this and I will repeat, we do not comment on rumors. I am sorry to disappoint you, sir, but that's always been our policy. Therefore, I don't change one iota on what has been said previously about this.

Unidentified Audience member

[inaudible] from Bear Stearns. Just a couple of pipeline questions. The first is actually a point of clarification on rimonabant. This doesn't seem to be included in your metabolic pipeline chart for obesity, although it is in phase IIb for smoking cessation. Is this an oversight or have you actually terminated development in obesity? And if so is this because of any associated -- any association between the mechanism of action acting more centrally than Acomplia?

And then the second question is actually on ABE1625, this presumably is from Aventis' pipeline previously, and can you let us know how you think this can be differentiated from Acomplia?

And final question is on Saredutant. How satisfied are you that the 100mg dose that you that you've chosen to pursue in the Phase III clinical program is the right dose in the majority? Thanks.

Unidentified Company Representative

Okay. I'll take this one. First Saredutant, I think it is an interesting story. When we started development of CD1 [inaudible] antagonist, we saw that most of the action of the CD1, all the action, in fact, in the beginning was to put the decontrol so acting through the [inaudible]. But to our big surprise, and it's a little bit why Gerard said that we should present the products the other way. We have said with rimonabant that most of the active benefit is relative mild CNS activity, if you consider that metabolic parameters were very, very reproducible.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

While the smoking-cessation effect, well it's a bit [inaudible] something like that. We discovered after that with rimonabant and also from some competitors than with Acomplia, we got perhaps the best in terms of base rate effect versus CNS effect and those products were a little bit more potent CNS versus base rate.

And clearly for [cirinabant] we do not get the same metabolic effects with the same weight reduction, and so we decided not to go for a metabolic disorders. Of course, the disadvantage may be an advantage, so we may think that in terms of working this position we should have a better effect with [cirinabant], which has a [inaudible] than for rimonabant, which has a much more prolific.

So, to simplify, for some reason that we do not know, there is some crossing of the potent barrier but it's not striking. So for some reason that we do not know rimonabant is clearly very, very CD1 [inaudible] to make it very simple, when [inaudible] is much more CNS side even [inaudible] the antagonist.

For [AVE1625], what we are doing for -- what we did for [inaudible]. We decided to calibrate all our CD1 with the antagonists in the most workable model and the most conceivable model is the weight-loss model. Because as you have seen [inaudible] so we can calibrate very quickly, except for AVE1625, whether to go only for the obesity.

We went also during the Phase IIb for obesity and limited associated disorders. So after that we see. You that there was specific development for [cirinabant] for AVE1625 in combination. So [inaudible].

And going for Saredutant, so far the profile of Saredutant was much more a [inaudible] profile than a true anti-depressive profile. So we think that the proposal should not be too far, but this is a good question. A little bit ranging in [inaudible].

Unidentified Audience member

Thank you.

Unidentified Company Representative

I can add that pharmacologically speaking, in other words in animals, the active boost in the anxiety model are the same that granted those on depression, it's in animal, exactly the same boost.

Unidentified Audience member

Thank you very much.

Ben Yeoh - Dresdner Kleinwort - Analyst

Hello it's Ben Yeoh at Dresdner Kleinwort. Three questions if I may. I was just wondering on value programs, the statement will be out in the first half of the year. I wondered whether you could give the headline data for that then or will we have to wait for a conference some time this year?

Secondly, I see that Plavix in combination with simvastatin seems to be on track for filing in 2009/2010, I was just wondering if there's any update on that, and what you see the potential population size is for that?

And then lastly, the question I guess I'm trying to get at your cost of goods. I was just wondering how many [inaudible] factories you currently have and whether that will be trending down in the next three years? You're something like at 40 and you think you might be at 30 in two or three years time.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Company Representative

I take the two first. On the value program it is true that we prefer to present data at a medical meeting just because that when we give data at a medical meeting we have sometimes a result and some [inaudible] of the result. I think it's more helpful that just a press release. But we actually can have a small press release and a presentation at the medical meeting.

As for the combi-statins with Plavix there is not too many reasons why it's not working. And as for the size of the market, very difficult to [inaudible] predict what will be the size of the market.

Unidentified Company Representative

[Interpreted]. On the manufacturing facilities, let me repeat what I tried to say earlier. Unlike one of our competitors who you are no doubt thinking of, we have not planned the slightest plant shutdown. We continue to keep the same manufacturing capability, we will adapt, depending on the units, what we have to produce during the year. But we don't plan to have a major reduction plan of our manufacturing facilities.

Ben Yeoh - Dresdner Kleinwort - Analyst

[Interpreted]. If there is no call for major restructuring -- manufacturing restructuring can we expect other restructuring in terms of the sales reps or will headcount remain stable in 2007?

Second, are you satisfied with your scope of business or is your business view as strategic today?

Unidentified Company Representative

[Interpreted]. On restructuring, we have not planned in terms of, as compared to what has already been described, we have no plans for additional structuring for Medical Reps in France given the present climate. Now if, of course, things were to deteriorate in the coming years, as we have done this year, and in the best and most suitable fashion consistent with our corporate culture we would do so, but on the face of it nothing is planned.

Ben Yeoh - Dresdner Kleinwort - Analyst

[Interpreted]. And given the scope, are you going to, in other words, as a subtext, is there a major acquisition of one of U.S. partners in the U.S. is that the subtext?

Unidentified Company Representative

[Interpreted]. I believe I've already answered that conversely. If you're referring to disposals, we have not planned the slightest disposal as of today. We will rather seek to develop as best we can our business.

And we've said this and we've attempted to say this, we are firmly of the view today given what's happening in terms of healthcare spending in all countries, we must be must be a global partner with countries to manage, at best, these increased health care products that are inevitable. You all know the population is aging. And so today the number of patients taking medicines is increasing and will increase over time. We will be taking medicines for longer and longer because people will live longer.

On the R&D we intend to beef up in biotech, not necessarily through acquisitions, possibly tie-ups. We'd like certainly to strengthen the balance between traditional pharma and biotech.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Audience member

-- with Goldman Sachs. Hanspeter, can you talk a little bit about the French and German markets, I know tough markets for us all to assess, but just wondered what the expectations are there maybe for 2007.

And second, Taxotere in the U.S. We're all aware of the dynamics there, but any reason why anything should change through 2007 for that product?

And then finally, one of the pipeline products, 5530, the cholesterol absorption inhibitor, wondering what your thought process is here with regard to strategy? And on the therapy combination with statins, how should we think about that product going forward?

Unidentified Company Representative

I will start with -- this kind of product is much more interesting in association than by [inaudible] and whether we do some kind of proposition to make. So I will not comment the evolution but to make an association.

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

Starting on Taxotere, I think there are a number of elements which make [inaudible] for 2007 in the U.S. First of all, if you really closely look, you see a certain acceleration in the marketplace, but you cannot [inaudible] in the second half of 2006 especially in the fourth quarter.

Second we have increased our investment, we have put more people behind the promotion because finally we thought that we are not sufficiently strong.

Third, we have two new indications or new indications have developed in gastric which we started to promote only fourth quarter. And last but not least, we have also changed the overall oncology management in the U.S.

So coming from all of this, I am confident that we will see a certain acceleration of our growth in the U.S. The growth was not so bad. Getting relatively close to 10%. So, yes, I'm a little bit optimistic but nevertheless I think we cannot overlook that the product, in its major indication, which is breast, of course, has a very, very solid for, not to say, perhaps even such as way that it positions. But yes, I hope to see more growth in 2007 than we have seen in 2006.

Now the other part of your question which goes to the environment in Germany and in France, I have to be a little bit less optimistic. We have no future indications for France as of today. But nevertheless, we will continue to suffer from the measures taken in 2006 for a large part of 2007 because they have been initiated largely in the second and in the third quarter 2006.

As you know, there will be elections in the not-so-far future in France. And also, from this background, it is impossible to say more than there is today, nothing reasonable which would further complicate the situation in France.

Now, in Germany, if there's any good news it's the very recent good news of last week where the Germany Government put an interpretation of the law in place which put the previous decisions of the so-called [IK-VIK] institute, which is an institute put them in place in order to make a secondary evaluation of the clinical benefits of otherwise already approved pharmaceuticals.

This new law has abandoned all pending decisions of the IK-VIK and gives a new guidance in the sense that IK-VIK has to incorporate international standards in its evaluations, which is exactly what we have been fighting for. Not only us, also the total industry.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

So this we see as a positive trend. But it is so recent that it is lacking really material impact so far. But at least the Government has recognized that the current practice, the previous practice of IK-VIK is not in line with international standards, to say the least. We have to see what comes out of it and we have been touched so far by IK-VIK in two respects.

First we lost [inaudible] of Apidra which at this point of time has been a small product in Germany, but nevertheless we assume Apidra now to be re-evaluated by IK-VIK.

And second, when IK-VIK was in the process of taking really a disastrous evaluation of Plavix, limiting Plavix indication to PAD only, which really highlights the practice of this institute because if you take this literally, it would mean that Plavix, for example, could not be used in [stents], which would be disastrous for the patient.

So we believe and we are convinced that, especially for Plavix, IK-VIK now is obliged to make a new evaluation and we hope very much that this evaluation is in line with treatment guidelines as, for example, the evaluation of Plavix in the U.K. or as in France.

But beyond, as I said in my opening chart, we have continual problems and effects that healthcare is improving faster than total economy. And so we will remain under pressure as an industry and we have to adapt to it.

Unidentified Audience member

[Interpreted]. [Merger Market], U.K. Press Agency. With that comment in BMS, could you perhaps tell us a little bit about your ambitions in terms of external growth if you have any for '07 on other continents, possibly smaller companies and, if so, what resources could you devote to that?

Secondly, more theoretical, all these problems with generics, don't they still militate in favor of a tie-up between Pharma firms because you say that everyone is treated in the same way?

Unidentified Company Representative

[Interpreted]. As Marc said, I believe that Jean-Francois announced it some time back in Lyon, if, indeed, we have a possibility or an opportunity on the side of a biotech company we will do so. And, as yet, we have not specifically identified a company. But this is part of something that might happen.

Second thing that we know is that it is always time consuming. Japan, you know full well that in Japan we have not yet achieved the critical mass. And if you have and if an opportunity arises in Japan, then again we are ready to invest. Having said that, let me repeat that we're used to working with Japan for many years now and we know that things take time, but it remains important objective for us.

As to a tie-up or a merger, the only point of mergers, and I'm not sure but it is because of generics, it's once it creates -- when it creates value, when it creates jobs and work for people. It won't just be a tie-up for the sake of a tie-up. But we're not sure that the size is really something that allows us to, quote unquote, to compensate for the generics for us.

We're put the necessary resources, we're put what it takes. Jean-Claude showed you at what speed we were capable of drawing down our debt, reimbursing our debt, we will have what it takes commensurate with our ambitions if need be, but we have no specific figure to give.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Max Heron - ING - Analyst

[Max Heron] from ING. Just another quick follow-on on the debt issue. You have paid it down very quickly, a lot of your peers are doing significant share buybacks. My question is do you have any plans in that area? And also what are your attitudes towards keeping the balance sheet geared on an ongoing basis?

And then secondly, just on xaliproden. Obviously coming to the end of the 18-month trial, of which patients have been on for 18 months, much longer than a typical acetyl cholinesterase inhibitor. I was wondering whether there was an open label portion of the study, obviously the effects being seen over a longer period then we typically see with current Alzheimer's drugs. Thanks.

Unidentified Company Representative

[Interpreted]. On the first part, the share buyback, as I indicated earlier. The focus during 2007 will be on a bigger payout of dividends on the 2006 earnings. What are we talking here? EUR1.75 per share, that's EUR2.4b over the year. So we expect to payout will remain the priority.

Of course, we are reducing our debt, but we started from EUR5.8m at the beginning of the year. And the share buyback isn't a priority 2007. You can never say never. Were the situation to justify it, but it is not on our list our priorities today.

It is true but, of course, we could say maybe we stand out from the other Pharma firms because the vast majority of other Pharma firms have a share buyback policy, so, in total, devoting bigger amounts than we are to all the shareholders. Not everyone is indebted as we were during the acquisition. I don't think we proceeded -- it was unwise, because, as you saw, we reduced the debt. And I would say that our financial charge has been not too high over the years. We benefited from the good rates and we'll see later.

Unidentified Company Representative

I think if you are going through your booklet, page 115 you will understand why we need to treat, at least for 18 months and perhaps even more. I don't know whether you can put it on the screen.

So because this is automatic treatment, you have an immediate effect and roughly you get in terms of the scope 4 points. The reaches of your [inaudible] is slowly decreasing with time, most of the time you stay above 4 points. So now if you have an agent like xaliproden, which is not improving [100%], but slowing, the disease.

And if you understand, here, look at the slide, so the effect of taking this is like [inaudible]. The first slide, the 115. So even if you take -- if you take the assumption that you have 30% of delay, which means with a [inaudible] of 6. points, which is even less now, we would like an effect of 1.5 to 2 points the first year.

But you have to compare this the 2 points to the 4 points that you have [inaudible]. So you need at least 18 months and perhaps more than 18 months in order to show the effect. And I remind you -- I would like to remind you that 30% to slow the disease is a lot. In oncology, most of the time you are in 10% response rate. In cardiovascular, you have most of the time in 20% range. So 30% is quite impressive. So there is not [inaudible]. And 18 months is really the minimum.

Unidentified Audience member

[Interpreted]. Could you tell us a little more about your strategy in terms of generics aside from what you already presented at the end of last year.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Company Representative

[Interpreted]. Well, it's quite simple. We are not considering becoming a major generics firm, as [Sandoz] is. If, depending on countries and regions, and we have, of course, the example of Zentiva, where we did special share ownership, if then we see geographical opportunities which seem to dovetail with the way we work, it may be that we will move into certain generics. But we certainly do not intend to go into head-on competition with generic firms.

Ivan Meu - La Monde - Media

[Interpreted]. Thank you. [Ivan Meu] from Le Monde. More and more major laboratories feel that a substantial proportion of their new drugs and approved drugs will have been acquired through external growth, that's between [60] and 65%. How do you feel about this?

Unidentified Company Representative

[Interpreted]. Well, if you buy a drug outside, you have to pay royalty fees already from the outset. It's cheaper not to have to do that. On the other hand, research is not always fully predictable. Sometimes the cycle is disrupted, interrupted. Sometimes there's additional research work to be done. So we're very much on the alert for molecules, compounds, which could better needs or so on. I'm thinking of S-1 or VEGF Trap, for that matter.

Unidentified Audience member

[Interpreted]. Could you give us a percentage? 15% internal research? What would you say?

Unidentified Company Representative

[Interpreted]: Well, I think that in pharmacy, in pharmaceuticals, when you start giving exact figures then you quickly get into hot water. We have some good [inaudible] that line up here that are from in-house, and that's a pretty good proportion. But it will probably be hard to maintain.

I'm not sure that there is an adequate level. I think you just have to take in the situation and fill in any gaps, whether we're talking about forms of therapy or molecule timing as the need arises. And I should say that in geographical sense we are very much in a pragmatic world than a dogmatic one, so please don't expect me to give you specific figures.

Unidentified Audience member

Just your decision concerning your possible partnership for investment in Japan. Which area are you most interested in, do you have a specific area which you are interested in? And also you interested in biotech companies, possibly acquiring one of them which is lot more active than a few years ago?

And secondly you talked about the importance of BRIC. But you are not still present, I believe, in countries like India or maybe Russia. How are you going to strengthen in these countries?

And thirdly, your R&D spending is 9.5% this year. Considering that you have a number of research -- number of clinical research going on in Phase IIb and III, this growth pace will it continue for next year -- for this year and for the next two or three years? Thank you.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Hanspeter Spek - *Sanofi-Aventis - EVP, Pharmaceutical Operations*

The R&D area where we could become active in Japan, through [inaudible], of course I can only answer to geographically. If you would acquire something, it would be easier in Tokyo or in [Osaka].

Unidentified Audience member

Not the area. I was talking about --.

Hanspeter Spek - *Sanofi-Aventis - EVP, Pharmaceutical Operations*

I know. But I meant that you must understand that we are not sitting here to share with you our potential targets. So I have to be a little bit joking on this subject.

On BRIC, I must slightly disagree. We have very strong positions in all relevant [free] countries. So to start with [inaudible]. We are number one in Russia. We are number two in India. We are number two amongst the international companies followed -- dominated only by -- slightly dominated by another European company, GSK, which is number one. And finally in India -- in China we are number two within the international companies once again.

So, of course, those are the positions and we have to take further decisions to develop and to grow them. Big decision, of course, is always should you have a manufacturing plant in Russia which is a long-lasting question inside this Company. And I'm not sure we will come to a conclusion in the very next future. But in terms of presence with our portfolio, in fact, we have the strongest division if I take all BRIC countries together for pharmaceutical industry.

On R&D spend?

Unidentified Company Representative

[Interpreted]. Perhaps I could answer for Marc on spending. We are not going into specific figures. We were talking about almost 10% increase this year. Perhaps it would be reasonable to say that the rate of increase of that spending will probably be slowed somewhat in 2007 in all likelihood. However, we do not hesitate to put how ever much money is necessary as the need arises. That has always been our policy.

And so we're not talking about some kind of ballpark figure that we would then hold to rather we look at the real need. And I should add, we are increasingly aware of the pressure that will apply to R&D costs. We try to reduce costs wherever we can to cut costs. We've already started to do that.

One of the best ways to cut costs is, of course, this is impossible to do in R&D, but it's not to make risky investments. And if you look at biotech, with the attrition rate is perhaps slightly lower than for pharmaceuticals. That could be one way of reducing R&D costs. So in fact very often the costs are not where you might expect them to be in terms of R&D.

Samuel Cohen - *DSM Radio - Media*

[Interpreted]. [Samuel Cohen] from [DSM Radio]. I was wondering if you have specific base for the [inaudible] French market for Acomplia. And could you tell us what your overall target for sales of Acomplia is?

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Company Representative

[Interpreted]: No, of course, we do not have those specifics dates, however it should be quite soon. Is that sufficiently accurate? I'm afraid it's the best I can do.

As for sales we do not have any figure to present you today. We are still talking with the Health Authorities. And, as you can easily imagine, it would be rather embarrassing to be talking about dates or sales figures when you're still negotiating with the French health authorities. Bearing in mind that we do have a marketing authorization for the E.U.

Just one additional point, as you will have seen, the file for the SERENADE application in December for Europe, and that may gradually lead to changes in the target population and the reimbursement time.

Unidentified Audience member

[Interpreted]. I have a question about your [diabetes] strategy. You have a strong position in insulin. I was wondering if you intend to be more comprehensive in diabetes terms, I'm thinking in particular of new action drugs. You talked about a [SL2] inhibitors today. I was also wondering if you are interested in having more oral drugs.

Unidentified Company Representative

[Interpreted]. Well, the one field with regard to the [DPP4] inhibitors, for different reasons, but [GLP1] you will have seen we are in process, GLP2 also. Acomplia, GLP1, -- GLP2, GLP2, Lantus, Apidra. There you have five products which are broadly around the same lines of course. For type 2 diabetes I think will be sub-segmentational. So I'm not going to tell you all about our vision, but you can certainly imagine some segments where the distribution of our product could be highly profitable.

Unidentified Audience member

[One Market]. Can you just comment on the dynamics you're seeing here, specifically the competitive changes from a sales and marketing prospective and the responses to that?

And then with regards to the GLP1 market, just how do you see that fitting into the insulin paradigm over time. You have a long acting GLP1, [inaudible] insulin market?

And then, with regards to Plavix in Japan, once the two-week prescription limit is lifted, how quickly should we expect uptake in that market? Thank you.

Unidentified Company Representative

When you are looking to Acomplia, definitely, at least for your subset of obese patients, at least, overweight patients with diabetes, it is a little bit of [a plus for] development, we should -- we are thinking that it is really the first part of the treatment.

Actually before diabetic, once you are diabetic it is very likely that the first line safe drug is Metformin, so that you can think about combination about Metformin. We are not sure that Metformin is not efficient enough, you have to go for association, so you can go for association for [inaudible] or for [inaudible] product at the present time. I am not sure, but at the end you have the insulin.

So I think we are going in the market by the two ends, those early phase and the late phase, for Lantus. The problem is trying to advance a little bit insulin or [indication] of the patient. So I think I answered your question correctly.

Feb. 13. 2007 / 2:30AM, SNY - Q4 2006 Sanofi-Aventis Earnings Conference Call

Unidentified Company Representative

Just to complete the part on the marketing and the sales force, or the commercial investment, I guess. It's really about market development activities. Let's say five years ago the major investments were focused on specialists and [inaudible]. And now the investments are focused not only on [others], but also are focused on GPs because it's also a market [inaudible] activity.

And this is trend that you see not only in the U.S., but the trend also that you see in Europe and in some other countries. And in this respect we are very well-positioned because we see the choice that we have done from the very beginning.

Hanspeter Spek - Sanofi-Aventis - EVP, Pharmaceutical Operations

The real different things in market today is the appearance of [Merck]. So what we see is that, yes, the shelf life has changed but, in fact we did it just last week, once again. If I look to the number of reps promoting any product in this field in the United States, we always had a very, very prominent position. And this has not changed in absolute terms by the appearance of Merck. But yes, Merck is significant player in this field and this has changed share of [inaudible].

Unidentified Audience member

[Interpreted]. Mr. Le Fur, you told us earlier, if I understood rightly, about the release of a drug which will be presented, Amadeus in Dijon on June 14. And I was wondering what types of diseases it will target.

Gerard Le Fur - Sanofi-Aventis - CEO

[Interpreted]. It must be idraparinux. The Amadeus study starts in early July, and the product is calls idraparinux. It's atrial fibrillation, avoiding cerebral events. Onset of stroke is a context of atrial fibrillation.

I get the feeling no one else has any questions. I'm afraid we've been rather lengthy, once again. We do wish to apologize for this. And thank you very much once again for being here with us today.

Editor

Portions of this transcript that are noted "interpreted" were interpreted on the conference call by an Interpreter present on the live call. The interpreter was provided by the Company sponsoring the Event.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2007, Thomson Financial. All Rights Reserved.

Exhibit CC



Paris, February 13, 2007

2006: In a difficult environment, another year of growth in adjusted EPS excluding selected items

Comparable net sales¹:	up 8.4% in Q4,	up 4.0% in 2006
Adjusted EPS¹:	down 5.6% in Q4,	up 10.3% in 2006
Adjusted EPS¹ excluding selected items²:	down 1.0% in Q4,	up 5.9% in 2006 at €4.88

The consolidated income statement for 2006 is provided in the appendices. Consolidated net income after minority interests for the period was €4,006 million, compared with €2,258 million in 2005, after the impact of the accounting treatment of acquisitions (primarily the acquisition of Aventis) and restructuring costs for a total amount of €3,034 million after tax in 2006 and €4,077 million in 2005.

In order to give a better representation of its underlying economic performance, the group has decided to present and explain an adjusted consolidated income statement¹ for 2006 and the fourth quarter of 2006, and to compare them with an adjusted consolidated income statement for 2005 and the fourth quarter of 2005 respectively. Adjusted net income for 2006 was €7,040 million, compared with €6,335 million for 2005.

Unless otherwise indicated, all sales growth figures in this press release are stated on a comparable basis¹.

FOURTH QUARTER: Sustained sales growth

- 8.4% growth (5.0% on a reported basis) in net sales to €7,356 million, despite the ongoing impact of healthcare reforms in France and Germany.
- Fourth-quarter sales impacted by a generic of clopidogrel bisulfate in the United States.
- 12.5% growth in "Operating income – current"
- Adjusted EPS of €1.02, down 5.6%, or €1.01 excluding selected items², down 1.0%.

2006 FULL-YEAR: Demonstrated ability to deliver EPS growth in a year penalized by generics

- Net sales: €28,373 million, up 4.0% (up 3.9% on a reported basis). Excluding the impact of generics of 4 products³ in the United States, sales growth would have been 8.2%.
- Sustained effort in R&D: up 9.5% to €4,430 million.
- Adjusted EPS of €5.23, up 10.3%.
- 5.9% growth in adjusted EPS excluding selected items² (to €4.88, against €4.61 in 2005).

R&D: Significant progress in pipeline with 46 projects in phase IIb/III compared to 35 in February 2006

DIVIDEND: 15.1% increase in the dividend to €1.75 per share to be submitted for approval at the Annual General Meeting of May 31, 2007

2007 GUIDANCE

Barring major adverse events (including events on Lovenox® and Plavix® in the US), the Group expects a growth in 2007 adjusted EPS excluding selected items in the same order of magnitude as 2006 growth, despite the end of protection for Ambien® IR in the United States in April 2007 and generic competition for Eloxatin® in Europe. (see hypothesis p13)

¹ Refer to the Appendices for definitions of financial indicators

² Refer to Appendix 6

³ Excluding net sales in the United States of Allegra®, Amarty®, Arava® and DDAVT® (generics introduced in the second half of 2005)

2006 fourth-quarter and full-year net sales

In the fourth quarter of 2006, sanofi-aventis recorded net sales of €7,356 million, a rise of 8.4%. Exchange rate movements (two-thirds relating to the U.S. dollar) had an unfavorable effect of 3.2 points. Changes in Group structure had a negative effect of 0.2 of a point. On a reported basis, net sales increased by 5.0%.

Full-year net sales rose by 4.0% to €28,373 million. Exchange rate movements had a favorable effect of 0.4 of a point. Changes in Group structure had a negative effect of 0.5 of a point. On a reported basis, net sales rose by 3.9%.

Net sales by business segment

Net sales reported by sanofi-aventis comprise net sales generated by the pharmaceuticals business and net sales generated by the human vaccines business.

Pharmaceuticals

Fourth-quarter net sales for the pharmaceuticals business reached €6,550 million, up 6.2%. Net sales of the top 15 products were 11.0% higher at €4,421 million, representing 67.5% of pharmaceuticals net sales, against 64.6% for the comparable period in 2005.

Over 2006 as a whole, pharmaceuticals net sales, despite being impacted by generics of 4 products⁴ in the United States and the effect of healthcare reforms in France and Germany, reach €25,840 million up 2.5%. Net sales of the top 15 products were up 6.4% at €17,289 million, representing 66.9% of pharmaceuticals net sales, compared with 64.4% in 2005. Excluding the impact of generics of Allegra® and Amaryl® in the United States, growth in net sales of the top 15 products would have been 12.4%.

€ million	Q4 2006 net sales	Change on a comparable basis	2006 net sales	Change on a comparable basis
Lovenox®	614	+11.8%	2,435	+12.9%
Plavix®	541	+5.0%	2,229	+9.6%
Stilnox®/Ambien®/Ambien CRT™	580	+42.5%	2,026	+33.3%
Taxotere®	437	+6.6%	1,752	+8.4%
Eloxatin®	402	-1.5%	1,693	+7.8%
Lantus®	451	+35.8%	1,666	+36.9%
Copaxone®	273	+11.0%	1,069	+17.9%
Aprovel®	265	+15.7%	1,015	+13.3%
Tritace®	271	-3.9%	977	-4.8%
Allegra®	163	+7.9%	688	-49.7%
Amaryl®	105	-19.8%	451	-33.5%
Xatral®	84	-5.6%	353	+7.3%
Actonel®	87	-1.1%	351	+6.7%
Depakine®	74	-6.3%	301	-5.3%
Nasacort®	74	+8.8%	283	+0.7%
TOTAL TOP 15	4,421	+11.0%	17,289	+6.4%
TOTAL TOP 15 excl. impact of Allegra® and Amaryl® in the USA*	4,325	+11.1%	16,890	+12.4%

* Excluding net sales of Allegra® and Amaryl® in the United States

⁴ Allegra®, Amaryl®, Arava®, DDAVP®

In the fourth quarter, net sales of other pharmaceutical products decreased by 2.5% to €2,129 million. This decrease reflects varied performances by geographical region. In Europe, net sales of other pharmaceutical products were adversely affected by healthcare reforms in France and Germany, down 4.1% to €1,278 million. In the rest of the world excluding the United States, net sales of these products rose by 4.4% to €671 million.

Over 2006 as a whole, net sales of other pharmaceutical products were down 4.6% at €8,551 million. This part of the portfolio showed a 4.1% increase in net sales to €2,614 million in the rest of the world excluding the United States, and a 5.3% decrease to €5,170 million in Europe.

Excluding the impact of generics of DDAVP® and Arava® in the United States⁵, net sales of other pharmaceutical products would have been down 2.4% in 2006.

Human Vaccines

Fourth-quarter consolidated net sales for the human vaccines business increased by 30.0% to €806 million. As expected, sales were helped by the postponement of US influenza vaccine sales from the third to the fourth quarter. The Group exceeded its target of delivering 50 million doses of Fluzone® in this territory in 2006 (55 million doses delivered).

Menactra® recorded fourth-quarter net sales of €45 million, up 46.9%, and 2006 full-year net sales of €242 million, an increase of 36.3%.

Sales of Adacel™ (adult tetanus-diphtheria-pertussis booster), launched in the United States in July 2005, reached €30 million in the fourth quarter and €154 million over the full year. A new production facility was approved by the FDA in August 2006 and should enable sanofi pasteur to better respond to demand for certain pertussis vaccines from 2007 onwards.

2006 full-year consolidated net sales for the human vaccines business reached €2,533 million, a rise of 22.7%. Full-year sales of H5N1 vaccines totaled €151 million. Sanofi pasteur also signed a new contract with the U.S. government in November 2006 for a stockpile of a new type of H5N1 pre-pandemic vaccine. The value of this contract could reach \$117.9 million, with the exact amount depending on the number of doses that can be produced. Shipment of the vaccine will take place in 2007.

€ million	Q4 2006 net sales	Change on a comparable basis	2006 net sales	Change on a comparable basis
Polio/Whooping Cough/Hib Vaccines	141	+28.2%	633	+18.5%
Adult Booster Vaccines	76	+33.3%	337	+23.4%
Influenza Vaccines	439	+36.8%	835	+27.5%
Travel Vaccines	48	+2.1%	239	+34.3%
Meningitis/Pneumonia Vaccines	57	+26.7%	310	+22.0%
Other vaccines	45	+12.5%	179	+5.3%
TOTAL	806	+30.0%	2,533	+22.7%

Fourth-quarter sales of Sanofi Pasteur MSD, the joint venture with Merck & Co in Europe, rose by 59.8% on a reported basis to €257 million. Quarterly sales benefited from the postponement of Vaxigrip® influenza vaccine sales from the third quarter to the fourth quarter.

⁵ Excluding net sales of Arava® and DDAVP® in the United States

Following its approval by the European Union, Gardasil® (Merck & co), the first vaccine designed to prevent genital warts caused by human papillomavirus (HPV) types 6, 11, 16 and 18, and in particular cervical dysplasia and carcinoma was launched by Sanofi Pasteur MSD. Gardasil is now available in 13 European countries, including France, Germany and the United Kingdom. Other countries, including Spain and Italy, will follow during 2007.

Rotateq® (Merck & Co) was approved by the European authorities in June 2006 for the prevention of rotavirus gastroenteritis in infants. It was launched by Sanofi Pasteur MSD in Austria, Portugal and Germany in October 2006 and in France in January 2007.

Sanofi Pasteur MSD posted 2006 full-year sales of €724 million, up 5.3% on a reported basis. Excluding Hexavac®, which was suspended by the EMEA in September 2005, Sanofi Pasteur MSD would have recorded growth in sales of 12.3% on a reported basis.

Sanofi Pasteur MSD sales are not consolidated by sanofi-aventis.

Net sales by geographical region

€ million	Q4 2006 net sales	Change on a comparable basis	2006 net sales	Change on a comparable basis
Europe	3,062	+1.0%	12,219	+1.1%
United States	2,661	+15.6%	9,966	+3.9%
Other countries	1,633	+12.4%	6,188	+10.5%
TOTAL	7,356	+8.4%	28,373	+4.0%

In Europe, fourth-quarter net sales were up slightly by 1.0%, in a context of ongoing healthcare reforms in France and Germany.

The German reforms, especially the pressure on doctors to curb prescriptions, led to a marked deceleration in the pharmaceutical market and in sanofi-aventis local sales during the third and fourth quarters. In addition, some of the Group products continued to be hit by parallel imports.

The reform of the healthcare system in France has involved higher taxes on reimbursed prescription drugs, reclassification of some products as non-reimbursable, and greater penetration of generics. The Group local sales, which are particularly vulnerable because of its position as market leader, were down significantly.

Over 2006 as a whole, net sales in Europe rose by 1.1%.

In the United States, fourth-quarter sales growth was driven notably by strong growth in sales of Ambien®/Ambien CR™, Lantus® and vaccines.

Over 2006 as a whole, sales grew by a modest 3.9%. Excluding the impact on sales of generic competition for 4 products³ in 2005, sales would have risen by 17.2%.

In "Other Countries", sales growth accelerated in the fourth quarter to 12.4%. Over the full year, sales growth was 10.5%. Latin America and Asia continue to record strong growth.

Developed sales¹

Developed sales give an indication of the overall presence of sanofi-aventis products in the market. Fourth-quarter developed sales were €7,937 million, a rise of 2.1%, reflecting the situation of Plavix® in the United States (see comments on developed sales of Plavix®). Over 2006 as a whole, developed sales grew by 2.6% to €31,575 million. From the first quarter of 2007, we will stop reporting developed sales. However, we will continue to comment on the worldwide presence of Plavix® and Aprovel®.

Developed sales of Plavix® / Iscover®:

€ million	Q4 2006	Change on a comparable basis	2006	Change on a comparable basis
Europe	436	+4.1%	1,715	+8.4%
United States	273	-61.5%	2,167	-16.4%
Other countries	183	+18.1%	702	+18.8%
TOTAL	892	-30.5%	4,584	-3.8%

On August 8, 2006, Apotex announced that it had launched a generic version of clopidogrel bisulfate 75 mg tablets in competition with Plavix® in the United States. On August 31, 2006, the U.S. District Court for the Southern District of New York granted the motion filed by sanofi-aventis and Bristol-Myers Squibb for a preliminary injunction and ordered Apotex to halt sales of its generic version of clopidogrel bisulfate. However, the Court did not order the recall of products already sold by Apotex.

As a result, sales of Plavix® in the United States have been hit hard since August 8, 2006. Fourth-quarter sales of Plavix® in the United States were €273 million. Growth in total prescriptions (TRx) of clopidogrel bisulfate remained strong, at 11.8%⁶ in the fourth quarter and 13.0%⁷ in 2006 as a whole. In the last week of December, the share of total clopidogrel bisulfate prescriptions taken by Plavix® was rising sharply, reaching 44.3%⁸, compared with 21.3%⁸ in the last week of September.

In August 2006, the Food and Drug Administration approved a new indication for Plavix® in patients suffering from acute ST-segment elevation myocardial infarction, to reduce the rate of death from any cause and the rate of a combined endpoint of re-infarction, stroke or death. The same indication was approved in the European Union in September 2006.

In Europe, fourth-quarter net sales of Plavix® rose by 4.1% to €436 million. This low rate of growth was largely due to a decline in sales in Germany, reflecting a marked slowdown in the local market as well as parallel imports, plus the effect of a 5% reduction in prices in France on September 1, 2006.

In Japan, the launch of Plavix® as a treatment for the reduction of recurrence after ischemic cerebrovascular disorder continued. The 6-month Post-Marketing Vigilance Period ended during the fourth quarter, though the two-week limit on prescriptions also imposed by the Japanese authorities will remain in force until May 2007. Full-year net sales were €12 million. The application relating to Plavix® as a treatment for acute coronary syndrome was filed with the Japanese authorities at the end of 2006.

⁶ IMS NPA 3 channels-Q4 2006

⁷ IMS NPA 3 channels- YTD 2006

⁸ IMS NPA 2 channels

Developed sales of Aprovel®/ Avapro®/ Karvea®:

€ million	Q4 2006	<i>Change on a comparable basis</i>	2006	<i>Change on a comparable basis</i>
Europe	229	+13.4%	878	+11.4%
United States	138	+5.3%	516	+12.7%
Other countries	98	+16.7%	370	+14.9%
TOTAL	465	+11.5%	1,764	+12.5%

Fourth-quarter developed sales of Aprovel®/Avapro®/Karvea® were up 11.5% at €465 million.

In the United States, the product posted net sales growth of 5.3% in the fourth quarter. Over the full year, total prescriptions were up 3.9%⁷.

Comments by product

Geographical split of consolidated net sales by product (Top 15)

Q4 2006 net sales (€ million)	Europe	Change on a comparable basis	United States	Change on a comparable basis	Other countries	Change on a comparable basis
Lovenox®	174	+7.4%	379	+14.2%	61	+10.9%
Plavix®	415	+7.5%	5	-87.2%	121	+34.4%
Stilnox®/Ambien®/Ambien CR™	23	-14.8%	532	+47.8%	25	25.0%
Taxotere®	178	+9.9%	174	+1.2%	85	+11.8%
Eloxatin®	124	-11.4%	235	1.7%	43	+16.2%
Lantus®	134	+19.6%	277	+42.8%	40	+53.8%
Copaxone®	72	+18.0%	186	+8.1%	15	+15.4%
Aprovel®	213	+15.1%	-	-	52	+18.2%
Tritace®	122	-17.6%	3	0.0%	146	+11.5%
Allegra®	8	-11.1%	93	+12.0%	62	+5.1%
Amaryl®	33	-44.1%	3	-66.7%	69	+9.5%
Xatral®	45	-26.2%	25	+47.1%	14	+27.3%
Actonel®	57	-9.5%	-	-	30	+20.0%
Depakine®	52	-8.8%	-	-	22	+0.0%
Nasacort®	9	0.0%	58	+11.5%	7	0.0%

2006 net sales (€ million)	Europe	Change on a comparable basis	United States	Change on a comparable basis	Other countries	Change on a comparable basis
Lovenox®	689	+6.5%	1,502	+16.0%	244	+13.5%
Plavix®	1,617	+9.5%	156	-26.1%	456	+32.2%
Stilnox®/Ambien®/Ambien CR™	95	-12.0%	1,838	+38.1%	93	+14.8%
Taxotere®	714	+14.2%	708	+1.0%	330	+13.8%
Eloxatin®	564	+3.7%	965	7.3%	164	+29.1%
Lantus®	520	+26.5%	1,006	+39.7%	140	+62.8%
Copaxone®	279	+20.8%	733	+17.5%	57	+9.6%
Aprovel®	808	+11.4%	-	-	207	+21.1%
Tritace®	509	-11.5%	16	+100.0%	452	+2.0%
Allegra®	51	-1.9%	384	-62.7%	253	-11.2%
Amaryl®	174	-31.5%	15	-91.9%	262	+10.1%
Xatral®	210	-10.3%	92	+73.6%	51	+21.4%
Actonel®	242	+3.4%	-	-	109	+14.7%
Depakine®	210	-10.3%	-	-	91	+8.3%
Nasacort®	41	+7.9%	214	-0.5%	28	0.0%

Net sales of **Lovenox®**, the leading low molecular weight heparin on the market, reached €614 million in the fourth quarter, a rise of 11.8%. Growth of the product continues to be driven by its increasing use in medical prophylaxis. Sales in Europe increased by 12.9%.

Filing for approval of Lovenox® as a treatment for patients suffering from acute ST-segment elevation myocardial infarction (ExTRACT study) took place in the fourth quarter in both Europe and the United States (priority review granted by the FDA). This new indication is expected to further enhance the superiority of Lovenox over non-fractionated heparins.

The results of the PREVAIL study were presented at the 48th annual congress of the American Society of Hematology (ASH) in Orlando in December 2006. The results demonstrated a significant 43% reduction in venous thromboembolism (VTE) events with enoxaparin versus unfractionated heparin (UFH) in medically-ill patients hospitalized for acute ischemic stroke.

Sales of **Plavix®** raw materials to the United States, which are consolidated by sanofi-aventis, fell by 87.2% to €5 million during the fourth quarter due to the launch of a generic version of clopidogrel bisulfate 75 mg tablets by Apotex. Excluding this effect, consolidated net sales of Plavix® would have risen by 12.6% in the quarter and by 13.3% over the full year.

Net sales of **Ambien®/Ambien CR™** in the United States rose by 47.8% in the quarter to €532 million. The products had a market share of 46.2%⁹ in December, versus 45.2% in September (IMS NPA-3 channels - September 2006). At end December, prescriptions of Ambien CR™ represented 31.8% of prescriptions of Ambien® brand products (IMS NPA Retail and Mail order).

At end November 2006, the FDA granted pediatric exclusivity to Ambien® and AmbienCR™. One effect of this decision is to delay the introduction of generics of Ambien® IR until April 2007.

In Japan, sales of Myslee® (developed sales) reached €119 million in 2006, an increase of 15.7%.

Taxotere® recorded strong fourth-quarter growth of 11.8% in "Other Countries" and 9.9% in Europe. In the United States, the competitive environment remains difficult, and the product posted sales growth of 1.2% to €174 million.

On December 14, 2006, results from the second interim efficacy and safety analysis from the BCIRG 006 Phase III breast cancer study were presented at the 29th Annual San Antonio Breast Cancer Symposium. These results confirmed, at a 3year median follow-up, that Herceptin® (trastuzumab) combined with Taxotere® (docetaxel) based regimens significantly improved disease-free survival for women with early HER2-positive breast cancer.

In 2006, Taxotere® was approved in the United States and Europe for two new indications:

- advanced stage gastric cancer in combination with the standard treatment (cisplatin and 5-fluorouracil)
- as induction treatment for patients with head and neck cancer in combination with a classic regimen (cisplatin and 5-fluorouracil).

The FDA has granted a pediatric extension for **Eloxatin®** in the United States, extending the data protection period by six months until February 2007, as well as the other regulatory exclusivity periods.

Fourth-quarter net sales of Eloxatin® in Europe were down 11.4% at €124 million due to the introduction of generics in Germany and the United Kingdom.

⁹ IMS NPA 3 channels-December 2006

Lantus®, the world's leading insulin brand, continues to record excellent performances, with net sales up 35.8% in the fourth quarter to €451 million. Net sales of the product in 2006 reached €1,666 million, up 36.9%. The new disposable pen, **Solostar®**, was approved in Europe in September 2006, and the application is currently under review in the United States. The first launch of **Solostar®** took place in the final quarter of 2006.

Acomplia® has been launched in the United Kingdom (end June 2006), Denmark (August), Germany, Ireland, Norway, Finland (all in September), Austria and Argentina (both in October), Sweden (November) and Greece (December). Fourth-quarter net sales were €20 million, and full-year net sales €31 million. The product was launched in Chile and Mexico in January 2007.

Acomplia® has been very favorably received by specialists and general practitioners for obese patients presenting cardiometabolic risk factors.

On January 12, 2007, the German Ministry of Health published its decision to ratify the recommendation of the Federal Joint Committee ("G-BA") to classify **Acomplia®** as a "comfort" or "lifestyle" drug, not available for reimbursement under the German compulsory health insurance scheme. Sanofi-aventis believes that this classification is unjustified given the profile of the drug, and is challenging it in court.

The results of the SERENADE study were presented on December 5, 2006 at the World Diabetes Congress of the International Diabetes Federation held in Cape Town, South Africa. The SERENADE results showed that patients receiving rimonabant showed significant improvements in blood sugar control and weight, as well as in other risk factors such as HDL-cholesterol (good cholesterol) and triglycerides, when compared to placebo in type 2 diabetes patients not currently treated with anti-diabetic medications. SERENADE is the second study, following RIO-DIABETES, to demonstrate that rimonabant significantly improves blood sugar control in type 2 diabetes patients.

The SERENADE dossier was filed with the European healthcare authorities in December 2006.

Regarding the ongoing review of rimonabant in the United States, a complete response to the approvable letter received from the FDA on February 17, 2006 was submitted by sanofi-aventis on October 26, 2006. The FDA has accepted this as a complete class 2 response, and set a user fee goal date of April 26, 2007.

An application for **Sculptra®** for volume restoration and/or correction of facial wrinkles and folds was filed with the FDA in the second half of 2006.

Adjusted consolidated income statement

The adjusted consolidated income statement is presented in Appendix 3.

Refer to Appendix 1 for a definition of "adjusted net income", and to Appendix 4 for a reconciliation of the consolidated income statement to the adjusted consolidated income statement.

Fourth quarter of 2006

Net sales generated by sanofi-aventis in the fourth quarter of 2006 rose by 5.0% on a reported basis to €7,356 million.

Gross profit was €5,627 million. The gross margin ratio was 76.5%, against 77.7% in the comparable period of 2005. This reduction was mainly due to two factors:

- A fall in other revenues (royalties) from €336 million to €228 million due to the marked drop in sales of Plavix® in the United States because of competition from a generic version.
- A 0.5 point improvement (to 26.6%) in the ratio of cost of sales to net sales. In the fourth quarter, the ratio of cost of sales to net sales was in line with the ratio for the first 9 months of 2006.

Research and development expenses were 5.3% higher at €1,211 million.

Selling and general expenses were 5.7% lower than in the fourth quarter of 2005 at €2,153 million, equivalent to 29.3% of net sales. There was a continuation in the quarter of the slowdown in selling expenses in the United States, Germany and France as sanofi-aventis adapted to the changing market environment. In the "Other Countries" zone, the group strengthened its marketing efforts. There was again a reduction in general expenses relative to the fourth quarter of 2005.

Operating income – current was up 12.5% at €2,272 million, and represented 30.9% of net sales as opposed to 28.8% in the fourth quarter of 2005.

The charge relating to sanofi-aventis' efforts to adapt to the changing market environment was €176 million.

The €214 million charge for asset impairment relates notably to the impairment of industrial assets associated with Ketek®, for which potential sales (€155 million in 2006) are affected by the restriction on indications in June 2006 and the recommendation of the FDA Joint Advisory Committee in December 2006.

Operating income was down 7.7% at €1,898 million.

Net financial income was €66 million, against net expense of €21 million for the comparable period of 2005. In 2006, the figure includes the €101 million capital gain arising on the divestment of the holding in Rhodia.

The interest charge on debt reached €36 million, against €79 million in the fourth quarter of 2005. In the fourth quarter, this figure included the full-year positive impact (€34 million) of the hedging of US commercial paper drawdowns using euro swaps. This amount was previously recorded in exchange gains and losses, a different component of financial income and expense.

Income tax expense was €534 million, against €643 million in the fourth quarter of 2005. The tax rate was 27.2%, against 31.6% for the comparable period of 2005. The fourth quarter of 2006 benefited from a net reduction in provisions for tax exposures.

The **share of profits from associates** was €50 million, compared with €140 million in the fourth quarter of 2005. This item was hit by the situation affecting Plavix® in the United States, and reflects the decline in the share of after-tax profits from territories managed by BMS (primarily the United States) under the Plavix® and Avapro® alliance (€12 million, against €109 million in the fourth quarter of 2005).

Minority interests totaled €103 million, against €88 million in the fourth quarter of 2005. This line includes the share of pre-tax profits paid over to BMS from territories managed by sanofi-aventis (€98 million, versus €80 million in the fourth quarter of 2005).

Adjusted net income was down 4.6% at €1,377 million.

Adjusted earnings per share (EPS) was €1.02, 5.6% lower than the 2005 fourth-quarter figure of €1.08, based on an average number of shares outstanding of 1,348.8 million in the fourth quarter of 2006 and 1,338.5 million in the fourth quarter of 2005.

After excluding selected items, adjusted net income was €1,368 million, up 0.6% on the 2005 fourth-quarter figure of €1,360 million (see Appendix 6).

After excluding selected items, adjusted EPS was €1.01, 1.0% lower than the 2005 fourth-quarter figure of €1.02 (see Appendix 6).

2006 full-year

Net sales generated by sanofi-aventis in 2006 were €28,373 million, an increase of 3.9% on a reported basis.

Gross profit was €21,934 million. The gross margin ratio was 77.3%, versus 78.1% in 2005. Other revenues were down 7.2% at €1,116 million, against €1,202 million in 2005, due to the drop in royalties generated by Plavix® in the United States since the third quarter. The ratio of cost of sales to net sales deteriorated by 0.3 of a point to 26.6%, with the impact of generics of Allegra®, Amaryl®, Arava® and DDAVP® in the United States over the first 9 months of 2006 not totally offset by the improvement in product mix

Research and development expenses were 9.5% higher than in 2005 at €4,430 million, representing 15.6% of net sales (versus 14.8% in 2005). The increase reflects the stepping up of phase III clinical trials during the year in pharmaceuticals and higher R&D spend in vaccines.

Selling and general expenses decreased 2.8% in 2005 to €8,020 million, or 28.3% of net sales, reflecting the rapid and selective adaptation of our resources.

Other current operating income and expenses totaled €275 million, against €137 million in 2005. The improvement was mainly due to the income generated by the agreement with Prasco on the marketing of authorized generics in the United States, plus a better foreign exchange result (net loss of €13 million in 2006, against a net loss of €79 million in 2005).

Operating income – current advanced by 6.1% to €9,627 million, and represented 33.9% of net sales, an improvement of 0.7 of a point on 2005.

The €176 million restructuring charge relates to the Group's efforts to adapt to changes in its market environment. The €217 million charge for the impairment of property, plant and equipment and intangibles relates notably to the impairment of industrial assets associated with Ketek®.

Other operating income and expenses totaled €536 million. This line includes gains on disposals of €550 million, of which €460 million (€384 million after tax) relates to Exubera® and €45 million to the sale of the residual 30% interest in an Animal Nutrition business.

Operating income was up 7.1% at €9,770 million.

Net financial expense came to €80 million, compared with €245 million in 2005. The reduction in net financial expense was mainly attributable to a reduction in debt due to the cash flow generated by sanofi-aventis. Interest charge on debt was €286 million, versus €418 million in 2005. In 2006, net financial expense benefited from the reclassification of the €34 million gain on hedging of US commercial paper drawdowns. Net financial expense was also helped by gains on financial instruments (€68 million, versus €49 million in 2005). Gains on disposals of investments in 2006 (€108 million, mainly Rhodia) were slightly ahead of those recorded in 2005 (€94 million).

Income tax expense was €2,816 million, compared with €2,774 million for 2005, giving a tax rate of 29.1%, against 31.3% for 2005. The effective tax rate was 30.6% in 2006.

The **share of profit from associates** totaled €559 million, compared with €584 million in 2005. This line includes the share of after-tax profits from territories managed by BMS (primarily the United States) under the Plavix® and Avapro® alliance (€320 million, compared with €404 million in 2005). These profits have been negatively impacted since third quarter by a generic of clopidogrel bisulfate in the United States. There was a significant increase in the contribution from Merial in 2006.

Minority interests amounted to €393 million, compared with €349 million in 2005. This line includes the share of pre-tax profits paid over to BMS from territories managed by sanofi-aventis (€375 million, versus €300 million in 2005).

Adjusted net income was up 11.1% at €7,040 million.

Adjusted earnings per share (EPS) was €5.23, 10.3% higher than in 2005 (€4.74), based on an average number of shares outstanding of 1,346.8 million in 2006 and 1,336.5 million in 2005.

Excluding selected items, adjusted net income was €6,571 million, 6.6% up on 2005 (€6,167 million) (see Appendix 6).

Excluding selected items, adjusted EPS was €4.88, 5.9% higher than in 2005 (€4.61) (see Appendix 6).

2006 consolidated statement of cash flows and balance sheet

Operating cash flow before changes in working capital totaled €7,610 million, against €6,637 million in 2005.

Working capital needs increased by €1,006 million, compared with €239 million in 2005. Operating working capital needs rose at a slightly higher rate than net sales: the usual time delay between the accounting recognition and payment of taxes had an adverse effect in 2006, as opposed to 2005 when these timing differences had a positive effect.

Investing activities generated net cash outflows of €790 million. Acquisitions of property, plant and equipment and intangibles amounted to €1,454 million, while acquisitions of investments totaled €509 million, the main item being the acquisition of a 24.87% interest in Zentiva (€433 million). Disposals generated €1,174 million net of taxes, the main items being the Exubera® rights (€821 million) and the interest in Rhodia (€182 million).

After the dividend payout of €2 billion, net cash generated during 2006 was €4.1 billion, enabling consolidated **net debt** to be cut from €9.9 billion at December 31, 2005 to €5.8 billion at December 31, 2006. Gearing stood at 12.6% at December 31, 2006, compared with 21.4% at December 31, 2005.

2007 Guidance

Barring major adverse events (including events on Lovenox® and Plavix® in the US), the Group expects a growth in 2007 adjusted EPS excluding selected items in the same order of magnitude as 2006 growth, despite the end of protection for Ambien® IR in the United States in April 2007 and generic competition for Eloxatin® in Europe.

This guidance is prepared using an exchange rate of 1 euro = 1.25 dollar, with sensitivity to the euro/dollar exchange rate estimated at 0.6% of growth for a 1-cent movement in the exchange rate.

2006 Dividend

Sanofi-aventis Board of Directors in its meeting of February 12, 2007, decided to ask the Shareholders' Annual General Meeting of May 31, 2007 to approve a dividend of €1.75 per share, an increase of 15.1% on the previous year (€1.52).

The dividend payment date will be June 7, 2007.

Research and Development

Sanofi-aventis research and development portfolio has made significant strides in the last one year. It currently has 46 projects in Phase IIb / Phase III compared to 35 in February 2006.

Since February 2006, the following projects entered either phase IIb or phase III:

- Three projects in oncology entered phase III (VEGF Trap, S-1 and XRP6258).
- Seven projects entered phase IIb:
 - AVE1625, a CB1 antagonist in obesity and related lipid disorders;
 - AVE 5530, a cholesterol absorption inhibitor;
 - AVE 5026, an indirect Xa/IIa inhibitor in thrombosis;
 - SSR149415, a VIB receptor antagonist in depression;
 - Surinabant (SR14778), a CB1 antagonist in smoking cessation.
 - Icatibant, a bradykinin B2 receptor antagonist in osteoarthritis;
 - Ferroquine in malaria.
- Five projects in vaccines entered phase III: Flu Micro-injection, Flu infants, Flu new formulation, Menactra® toddler 1-2 years, Unifive™ (combination vaccine). The project for pandemic flu is in phase IIb.

Two projects were discontinued; tirapazamine in head and neck cancer and SR31747 in prostate cancer.

The highlights of the progress made in the R&D projects are as follows:

Metabolic disorders:

Acomplia® (rimonabant): Results of a 526-patient phase IIb study conducted in Japan provided the first data in an Asian patient population. The study demonstrated an impressive consistency in terms of benefits on cardiometabolic risk factors with results of previous studies. In addition, a reduction in visceral fat was observed in patients who underwent a CT-scan. Rimonabant demonstrated a good safety profile. Phase III trials are currently in progress for two indications: diabetes and weight management. The company intends to submit the registration file in 2009 in Japan.

AVE2268, a new renal SGLT2 inhibitor, demonstrated proof of concept in a phase I study. Phase IIb trials with AVE 2268 have been initiated. Results are expected in Q4 2007.

Thrombosis:

Biotinylated idraparinux (SSR126517) is a neutralizable selective inhibitor of coagulation factor Xa. SSR126517 is a long-acting synthetic pentasaccharide, with the addition of biotin hook allows quick and efficient neutralization following the infusion of avidin. This unique profile provides SSR126517 potentially with a competitive advantage over current oral anticoagulants. The clinical development program was designed to bridge clinical results obtained with idraparinux. In Deep Vein Thrombosis, a bioequipotency study, EQUINOX, was initiated in 2006. Another study was also initiated in pulmonary embolism, CASSIOPEA. A Phase III trial to demonstrate the efficacy of biotinylated idraparinux in the prevention of stroke in Atrial Fibrillation patients is scheduled to start in H2 2007.

SR123781 is a synthetic short-acting hexadecasaccharide which exhibit highly potent indirect factor Xa and factor IIa inhibition properties. SR123781 is currently being studied in two phase IIb studies: the DRIVE trial in patients undergoing total hip replacement surgery, and the SHINE study in patients with non-ST elevated acute coronary syndrome. Results of both studies are expected in H2 2007.

AVE5026 is a ultra low molecular weight heparin with a high ratio of anti-factor Xa activity to anti-factor IIa activity, as compared to low-molecular-weight heparins. This once-a-day antithrombotic agent is being developed primarily in the prevention of venous thromboembolic events in cancer patients. Phase IIb results are expected in H2 2007.

Otamixaban (XRP0673) is a synthetic, short-acting, direct and selective factor Xa inhibitor displaying a quick onset/offset (short initial half-life) designed for use in acute coronary syndrome patients undergoing invasive treatment. The primary targeted indication is the treatment of acute coronary syndrome. SEPIA-PCI, a phase IIa study showed a good safety profile with predictable and dose proportional anticoagulant activity. SEPIA-ACS, a phase IIb study, is being initiated.

Cardiovascular:

Multaq (dronedarone) is a new anti-arrhythmic agent developed for the treatment of atrial fibrillation. The ATHENA morbi-mortality study has completed enrollment of 4,600 patients. Results of ATHENA will be available early 2008. Depending upon the results of this study, the company's intention is to submit a new marketing authorization application in 2008.

Celivarone (SSR149744C) is a new anti-arrhythmic once-a-day drug developed for the treatment of atrial fibrillation. The 673-patient MAIA study showed a trend towards reduction in recurrences of atrial fibrillation events at a dose of 50mg/day vs. placebo. It also demonstrated a good safety profile at all tested doses (i.e. 50 to 300mg/day) and absence of dose-effect relationship. A new study is under preparation to evaluate lower doses.

NV1FGF (XRP0038) is an injectable non-viral DNA plasmid and gene therapy-based approach for the promotion of angiogenesis in CLI (Critical Limb Ischemia). This innovative approach may have the potential to reduce the number of amputations and potentially to replace invasive methods like angioplasty and surgery. NV1FGF will enter Phase III of development in Q2 2007.

Central nervous system:

Saredutant (SR48968) is a NK2 receptor antagonist in phase III for the treatment of Major Depressive Disorder (MDD) and General Anxiety Disorder (GAD). Four phase III studies (two studies statistically significant, two studies not statistically significant versus placebo) evaluating saredutant in the treatment of MDD demonstrated a statistically significant overall efficacy versus placebo on depressive symptoms. Saredutant was very well tolerated in these studies.

In addition, results of four other phase III studies are expected in 2007/2008.

Amibegron (SR58611) is a selective beta 3 agonist also in phase III in MDD and GAD. The company is currently conducting six phase III trials in MDD as well as five trials in GAD. The total number of patients enrolled exceeds 4,500. Initial results will become available in H2 2007.

Internal medicine:

Icatibant (HOE140), bradykinin B2 receptor antagonist, demonstrated effective, quick and sustained pain relief for osteoarthritis of the knee in a phase II trial. Results of the on-going phase IIb study are expected in Q2 2007.

Satavaptan (SR121463), a vasopressin V2 receptor antagonist, confirms in study DFI4522 that a pure aquaretic agent has therapeutic interest in the reduction in the number of paracentesis in recurrent ascites.

Ferroquine (SR97193), studied in the treatment of malaria entered into phase IIb.

Oncology:

S-1 (agreement with Taiho) is a novel oral 5FU derivative which delivers improvements on current fluoropyrimidine-based cancer therapies. In collaboration with Taiho, sanofi-aventis is conducting a registration seeking Phase III study, the FLAGS study, in first line advanced gastric cancer. Recruitment of the 1,050-patient targeted population is expected to complete in Q2 2007. Sanofi-aventis is also evaluating further development activities of S-1 in colorectal cancer, breast cancer and other 5-FU sensitive tumors.

Larotaxel (XRP9881) is a new taxane derivative. In a phase II study, larotaxel in monotherapy has proved to be active in metastatic breast cancer progressing after anthracycline/taxane, but did not reach superiority in a phase III study versus capecitabine in the same population. Following these results showing potential better efficacy and safety than Taxotere, a large phase III program in association with other cytotoxic agents is being implemented in breast and pancreas cancer.

XRP6258 is another new taxane derivative. It entered phase III development in the treatment of hormone refractory metastatic prostate cancer previously treated with a Taxotere containing regimen.

VEGF Trap (AVE0005) (agreement with Regeneron) is a new antiangiogenic agent to prevent neo-vascularization processes in tumors. Five Phase III studies in combination with chemotherapy in patients with several solid tumors are scheduled to start in 2007. The first potential regulatory submission is planned in 2008.

Vaccines:

Menactra®, a conjugate vaccine to protect against Meningitis A/C/Y/W, is currently licensed in the USA as a single dose product for 11-55 years. A supplement for 2-10 years is under FDA review with licensure expected in 2007. Menactra® Toddler, which would be targeted at toddlers between 1-2 years, has moved to Phase III (following successful Phase IIB) and this development project has been given a "fast track" designation by the FDA. The expected filing date for Menactra® Toddler is 2009.

The advisory committee to the U.S. Food and Drug Administration (FDA) voted unanimously that **Pentacel**® (DTaP-IPV-Hib), company's pentavalent combination vaccine for use in pediatric patients, is both safe and efficacious. Pentacel vaccine protects against diphtheria, tetanus, pertussis, polio, and *Haemophilus influenzae* type b (Hib). According to the current Recommended Childhood and Adolescent Immunization Schedule from the Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC), up to 23 injections are needed through 18 months of age. The use of Pentacel® could reduce that number of shots by seven. Sanofi Pasteur expects Pentacel® to be licensed by the FDA soon.

Two other combination vaccines, **Hexaxim**™ and **Unifive**™, tailored for the International markets, are in extensive Phase III clinical testing.

Flu micro-injection, providing superior immune response in the elderly, has entered Phase III and will be filed this year. A new formulation of flu vaccine and a flu vaccine for infants (6 weeks to 6 months age) entered also in phase III in the US.

Phase I studies with a cell culture flu vaccine have been initiated.

Sanofi Pasteur has submitted a BLA supplement for a pre pandemic H5N1 vaccine without adjuvant with the US FDA. In Europe, results obtained in a Phase II study in 600 healthy adults and elderly persons will

allow Sanofi Pasteur to file a "mock up" dossier in 2007. The company has also initiated phase 1 study with H5N1 and a novel adjuvant.

Forward Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expect," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements

Recent Events

October 25, 2006	Presentation of a reorganization plan for the commercial subsidiary of sanofi-aventis in France.
November 9, 2006	Marketing authorization granted for Acomplia™ in Mexico.
November 10, 2006	Announcement of reimbursement of Acomplia™ in Sweden for overweight patients with associated risk factors
November 13, 2006	Announcement of a collaborative agreement with Inserm and Innogenetics in Alzheimer's disease.
November 20, 2006	Signature of a contract between the U.S. government and sanofi pasteur for a stockpile of new type of H5N1 pre-pandemic vaccine.
November 27, 2006	Announcement of the successful completion of the shipment of 50 million doses of influenza vaccine in the United States.
November 29, 2006	Granting of pediatric exclusivity for Ambien® and Ambien CR® in the United States.
December 5, 2006	Presentation of the results of the SERENADE study at the World Diabetes Congress of the International Diabetes Federation, showing significant improvements in blood sugar control and weight when compared to placebo in type 2 diabetes patients not currently treated with anti-diabetic medications.
December 8, 2006	Announcement that the resubmission to the FDA relating to the new drug application for rimonabant had been accepted as a complete class 2 response. The user fee goal date is April 26, 2007.
December 8, 2006	Announcement that the Federal Court of Appeal had upheld the preliminary injunction issued against Apotex on August 31, 2006 by the U.S. District Court for the Southern District of New York.
December 10, 2006	Announcement of encouraging results for Idraparinux in the Van Gogh clinical trials program.
December 12, 2006	Presentation of positive results from the PREVAIL study at the 48th Congress of the American Society of Hematology, showing that Lovenox® is more effective than unfractionated heparin for preventing the risk of venous thromboembolism in patients with acute ischemic stroke.
December 14, 2006	Presentation at the 29th Annual San Antonio Breast Cancer Symposium of results from the second interim efficacy and safety analysis from the BCIRG 006 Phase III breast cancer study, which confirm at a 3-year median follow-up that Herceptin® combined with Taxotere®-based regimens significantly improved disease-free survival for women with early HER2-positive breast cancer.
December 15, 2006	Statement from sanofi-aventis regarding the FDA Joint Advisory Committee recommendation for Ketek®.
December 20, 2006	Announcement by sanofi pasteur that it had produced over 170 million doses of influenza vaccine during 2006.
December 28, 2006	Announcement that the Canadian Federal Court of Appeals had ruled in sanofi-aventis' favor in the Canadian Plavix® Notice of Compliance Proceedings.
January 12, 2007	Publication in the official journal of the German government of the decision by the German Ministry of Health to classify Acomplia® as a non-reimbursable "comfort" drug. Sanofi-aventis believes this classification to be unjustified given the profile of the drug, and intends to challenge it in court.
January 19, 2007	Presentation of results of a phase III study (ACTS-GC) at the 2007 Gastrointestinal Cancers Symposium in Orlando, USA, showing

	that the oral anticancer agent S-1 reduced significantly the relative risk of death in early stage gastric cancer patients by a significant 32 % as compared to curative surgery alone
January 25, 2007	FDA advisory committee recommends licensure of Pentacel®
February 6, 2007	Announcement that the FDA grants priority review to Lovenox® supplemental new drug application for additional type of heart attack
February 6, 2007	Positive recommendation for Acomplia® from the Transparency Committee in France
February 9, 2007	Announcement that the Court ruled against sanofi-aventis in its Lovenox® suit against Amphastar and Teva

Financial Timetable

May 3, 2007	2007 first-quarter sales and results
May 31, 2007	Shareholders' Annual General Meeting
August 1, 2007	2007 second-quarter sales and results
September 17, 2007	Research and Development meeting
October 31, 2007	2007 third-quarter sales and results

Appendices

List of appendices

- Appendix 1: Explanatory notes
- Appendix 2: 2006 fourth-quarter and full-year net sales by product
- Appendix 3: 2006 fourth-quarter and full-year adjusted consolidated financial statements
- Appendix 4: 2006 fourth-quarter and full-year reconciliations of consolidated income statement to adjusted consolidated income statement
- Appendix 5: Simplified consolidated balance sheet/consolidated statement of cash flows
- Appendix 6: Trends in selected adjusted income statement items

Appendix 1: Explanatory notes

Comparable net sales

When we refer to the change in our sales on a "comparable" basis, we mean that we exclude the impact of exchange rate movements and changes in Group structure (acquisitions and divestments of interests in entities and rights to products, and changes in consolidation method for consolidated entities).

We exclude the impact of exchange rates by recalculating sales for the prior period on the basis of exchange rates used in the current period. We exclude the impact of acquisitions by including sales from the acquired entity or product rights for a portion of the prior period equal to the portion of the current period during which we owned them, based on sales information we receive from the party from whom we make the acquisition.

Similarly, we exclude sales in the relevant portion of the prior period when we have sold an entity or rights to a product.

For a change in consolidation method, the prior period is recalculated on the basis of the method used for the current period.

Reconciliation of 2005 fourth-quarter net sales to 2005 fourth-quarter comparable net sales

€ million	Q4 2005
Q4 2005 net sales	7,007
Impact of changes in Group structure	(15)
Impact of exchange rates	(205)
Q4 2005 comparable net sales	6,787

Reconciliation of 2005 full-year net sales to 2005 full-year comparable net sales

€ million	2005
2005 full-year net sales	27,311
Impact of changes in Group structure	(151)
Impact of exchange rates	116
2005 full-year comparable net sales	27,276

Developed sales

When we refer to "developed sales" of a product, we mean our consolidated net sales minus sales of products to our alliance partners plus non-consolidated sales made through our alliances with Bristol-Myers Squibb on Plavix®/Iscover® (clopidogrel) and Aprovel®/Avapro®/Karvea® (irbesartan) and Fujisawa on Stilnox®/Myslee® (zolpidem). Our alliance partners provide us with information regarding their sales in order to allow us to calculate developed sales.

We believe that developed sales are a useful measurement tool because they demonstrate trends in the overall presence of our products in the market.

Reconciliation of net sales to developed sales

€ million	Q4 2006
Net sales	7,356
Non-consolidated sales of Plavix®/Iscover®, net of sales of product to BMS	351
Non-consolidated sales of Aprovel®/Avapro®/Karvea®, net of sales of product to BMS	200
Non-consolidated sales of Stilnox®/Myslee®, net of sales of product to Fujisawa	30
Developed sales	7,937

€ million	2006 full-year
Net sales	28,373
Non-consolidated sales of Plavix®/Iscover®, net of sales of product to BMS	2,355
Non-consolidated sales of Aprovel®/Avapro®/Karvea®, net of sales of product to BMS	749
Non-consolidated sales of Stilnox®/Myslee®, net of sales of product to Fujisawa	98
Developed sales	31,575

Adjusted net income

We define "adjusted net income" as accounting net income after minority interests (determined under IFRS) adjusted to exclude (i) the material impacts of the application of purchase accounting to acquisitions and (ii) acquisition-related integration and restructuring costs. Sanofi-aventis believes that eliminating these impacts from net income gives investors a better understanding of the underlying economic performance of the combined Group.

The material impacts of the application of purchase accounting to acquisitions, primarily the acquisition of Aventis, are as follows:

- Charges arising from the remeasurement of inventories at fair value, net of tax
- Amortization/impairment expense generated by the remeasurement of intangible assets, net of tax
- Any impairment of goodwill

Sanofi-aventis also excludes from adjusted net income any integration and restructuring costs that are specific to the acquisition of Aventis by sanofi-aventis.

€ million	Q4 2006 Consolidated financial statements (unaudited)	Q4 2006 Adjusted consolidated financial statements (unaudited)	2006 full-year Consolidated financial statements	2006 full-year Adjusted consolidated financial statements
Net sales	7,356	7,356	28,373	28,373
Net income*	575	1,377	4,006	7,040
Basic EPS	0.42	1.02	2.97	5.23

* After minority interests

Appendix 2: 2006 fourth-quarter and full-year net sales by product**2006 fourth-quarter net sales by product**

€ million	Q4 2006 net sales	Q4 2005 comparable net sales	Q4 2005 reported net sales
Lovenox®	614	549	572
Plavix®	541	515	518
Stilnox®/Ambien®/Ambien CR™	580	407	430
Taxotere®	437	410	425
Eloxatin®	402	408	423
Lantus®	451	332	345
Copaxone®	273	246	256
Aprove®	265	229	231
Tritace®	271	282	285
Allegra®	163	151	160
Amaryl®	105	131	135
Xatral®	84	89	91
Actonel®	87	88	89
Depakine®	74	79	80
Nasacort®	74	68	72
TOTAL	4,421	3,984	4,112
Other products	2,129	2,183	2,252
TOTAL Pharmaceuticals	6,550	6,167	6,364
Vaccines	806	620	643
TOTAL Net sales	7,356	6,787	7,007

2006 full-year net sales by product

€ million	2006 full-year net sales	2005 full-year comparable net sales	2005 full-year reported net sales
Lovenox®	2,435	2,157	2,143
Plavix®	2,229	2,033	2,026
Stilnox®/Ambien®/Ambien CR™	2,026	1,520	1,519
Taxotere®	1,752	1,616	1,609
Eloxatin®	1,693	1,570	1,564
Lantus®	1,666	1,217	1,214
Copaxone®	1,069	907	902
Aprove®	1,015	896	892
Tritace®	977	1,026	1,009
Allegra®	688	1,367	1,345
Amaryl®	451	678	677
Xatral®	353	329	328
Actonel®	351	329	364
Depakine®	301	318	318
Nasacort®	283	281	278
TOTAL	17,289	16,244	16,188
Other products	8,551	8,968	9,061
TOTAL Pharmaceuticals	25,840	25,212	25,249
Vaccines	2,533	2,064	2,062
TOTAL Net sales	28,373	27,276	27,311

Appendix 3: 2006 fourth-quarter and full-year adjusted consolidated financial statements**2006 fourth-quarter adjusted consolidated financial statements (unaudited)**

€ million	Q4 2006 Adjusted consolidated income statement (unaudited)	as % of net sales	Q4 2005 Adjusted consolidated income statement (unaudited)	as % of net sales	% change
Net sales	7,356	100.0%	7,007	100%	+5.0%
Other revenues	228	3.1%	336	4.8%	-32.1%
Cost of sales	(1,957)	(26.6%)	(1,901)	(27.1%)	+2.9%
Gross profit	5,627	76.5%	5,442	77.7%	+3.4%
Research and development expenses	(1,211)	(16.5%)	(1,150)	(16.4%)	+5.3%
Selling and general expenses	(2,153)	(29.3%)	(2,283)	(32.6%)	-5.7%
Other current operating income	69	-	69	-	-
Other current operating expenses	(30)	-	(30)	-	-
Amortization of intangibles	(30)	-	(28)	-	+7.1%
Operating income – current	2,272	30.9%	2,020	28.8%	+12.5%
Restructuring costs	(176)	-	5	-	-
Impairment of PP&E and intangibles	(214)	-	(4)	-	-
Other operating income and expenses	16	-	35	-	-54.3%
Operating income	1,898	25.8%	2,056	29.3%	-7.7%
Financial expenses	(56)	-	(104)	-	-46.2%
Financial income	122	-	83	-	+47.0%
Income before tax and associates	1,964	26.7%	2,035	29.0%	-3.5%
Income tax expense	(534)	(7.3%)	(643)	(9.1%)	-17.0%
Effective tax rate	27.2%	-	31.6%	-	-
Share of profit/loss of associates	50	-	140	-	-64.3%
Consolidated net income	1,480	20.1%	1,532	21.9%	-3.4%
Minority interests	103	-	88	-	+17.0%
Net income after minority interests	1,377	18.7%	1,444	20.6%	-4.6%
Average number of shares outstanding (millions)	1,348.8		1,338.5		
Earnings per share (in euros)	1.02		1.08		-5.6%

2006 full-year adjusted consolidated financial statements

€ million	2006 full-year Adjusted consolidated income statement	as % of net sales	2005 full-year Adjusted consolidated income statement	as % of net sales	% change
Net sales	28,373	100.0%	27,311	100%	+3.9%
Other revenues	1,116	3.9%	1,202	4.4%	-7.2%
Cost of sales	(7,555)	(26.6%)	(7,172)	(26.3%)	+5.3%
Gross profit	21,934	77.3%	21,341	78.1%	+2.8%
Research and development expenses	(4,430)	(15.6%)	(4,044)	(14.8%)	+9.5%
Selling and general expenses	(8,020)	(28.3%)	(8,250)	(30.2%)	-2.8%
Other current operating income	391	-	261	-	+49.8%
Other current operating expenses	(116)	-	(124)	-	-6.5%
Amortization of intangibles	(132)	-	(112)	-	+17.9%
Operating income – current	9,627	33.9%	9,072	33.2%	+6.1%
Restructuring costs	(176)	-	(25)	-	-
Impairment of PP&E and intangibles	(217)	-	(7)	-	-
Other operating income and expenses	536	-	79	-	-
Operating income	9,770	34.4%	9,119	33.4%	+7.1%
Financial expenses	(455)	-	(532)	-	-14.5%
Financial income	375	-	287	-	+30.7%
Income before tax and associates	9,690	34.2%	8,874	32.5%	+9.2%
Income tax expense	(2,816)	(9.9%)	(2,774)	(10.1%)	+1.5%
Effective tax rate	29.1%	-	31.3%	-	-
Share of profit/loss of associates	559	-	584	-	-4.3%
Consolidated net income	7,433	26.2%	6,684	24.5%	+11.2%
Minority interests	393	-	349	-	+12.6%
Net income after minority interests	7,040	24.8%	6,335	23.2%	+11.1%
Average number of shares outstanding (millions)	1,346.8		1,336.5		
Earnings per share (in euros)	5.23		4.74		+10.3%

Appendix 4: 2006 fourth-quarter and full-year reconciliations of consolidated income statement to adjusted consolidated income statement

2006 fourth-quarter reconciliation of consolidated income statement to adjusted consolidated income statement (unaudited)

The adjustments to the income statement reflect the elimination of material impacts of the application of purchase accounting to acquisitions, primarily the acquisition of Aventis, amounting to €802 million net of deferred taxes (with no cash impact for the Group).

€ million	Q4 2006 Consolidated (unaudited)	Adjustments	Q4 2006 Adjusted consolidated (unaudited)
Net sales	7,356		7,356
Other revenues	228		228
Cost of sales	(1,976)	19 (a)	(1,957)
Gross profit	5,608	19	5,627
Research and development expenses	(1,211)		(1,211)
Selling and general expenses	(2,153)		(2,153)
Other current operating income	69		69
Other current operating expenses	(30)		(30)
Amortization of intangibles	(974)	944 (b)	(30)
Operating income - current	1,309	963	2,272
Restructuring costs	(176)		(176)
Impairment of PP&E and intangibles	(785)	571 (c)	(214)
Other operating income and expenses	16		16
Operating income	364	1,534	1,898
Financial expenses	(56)		(56)
Financial income	122		122
Income before tax and associates	430	1,534	1,964
Income tax expense	218	(752) (d)	(534)
Share of profit/loss of associates	30	20 (e)	50
Consolidated net income	678	802	1,480
Minority interests	103		103
Net income after minority interests	575	802	1,377
Average number of shares outstanding (millions)	1,348.8		1,348.8
Earnings per share (in euros)	0.42	0.60	1.02

The material impacts of the application of purchase accounting to acquisitions (primarily the acquisition of Aventis) and of restructuring charges on the 2006 fourth-quarter consolidated income statement are:

- a) A charge of €19 million arising from the workdown of acquired inventories remeasured at fair value. This adjustment has no cash impact on the Group
- b) An amortization charge of €944 million against intangible assets. This adjustment has no cash impact on the Group.
- c) An impairment loss of €571 million, relating primarily to Ketek and to the launch of a generic of Ramipril in Canada. This adjustment has no cash impact on the Group.
- d) The tax impact primarily comprises:
 - 1. Deferred taxes of €662 million generated mainly by the amortization charge of €944 million taken against intangible assets, impairment losses on intangibles of €571 million, and the €19 million charge arising from the workdown of acquired inventories remeasured at fair value. This adjustment has no cash impact on the Group.
 - 2. Reversal of deferred tax liabilities of €90 million due to the tax exemption of some internal capital gains on investments.
- e) In "Share of profit/loss from associates", a €20 million charge corresponding to amortization and impairment of intangibles (net of tax). This adjustment has no cash impact on the Group.

2006 full-year reconciliation of consolidated income statement to adjusted consolidated income statement

The adjustments to the income statement reflect the elimination of material impacts of the application of purchase accounting to acquisitions, primarily the acquisition of Aventis, amounting to €2,969 million net of deferred taxes (with no cash impact for the Group) and restructuring charges (€65 million net of tax), i.e. a total impact of €3,034 million.

€ million	2006 Consolidated	Adjustments	2006 Adjusted consolidated
Net sales	28,373		28,373
Other revenues	1,116		1,116
Cost of sales	(7,587)	32 ^(a)	(7,555)
Gross profit	21,902	32	21,934
Research and development expenses	(4,430)		(4,430)
Selling and general expenses	(8,020)		(8,020)
Other current operating income	391		391
Other current operating expenses	(116)		(116)
Amortization of intangibles	(3,998)	3,866 ^(b)	(132)
Operating income - current	5,729	3,898	9,627
Restructuring costs	(274)	98 ^(c)	(176)
Impairment of PP&E and intangibles	(1,163)	946 ^(d)	(217)
Other operating income and expenses	536		536
Operating income	4,828	4,942	9,770
Financial expenses	(455)		(455)
Financial income	375		375
Income before tax and associates	4,748	4,942	9,690
Income tax expense	(800)	(2,016) ^(e)	(2,816)
Share of profit/loss of associates	451	108 ^(f)	559
Consolidated net income	4,399	3,034	7,433
Minority interests	393		393
Net income after minority interests	4,006	3,034	7,040
Average number of shares outstanding (millions)	1,346.8		1,346.8
Earnings per share (in euros)	2.97	2.26	5.23

The material impacts of the application of purchase accounting to acquisitions (primarily the acquisition of Aventis) and of restructuring charges on the 2006 full-year consolidated income statement are as follows:

- a) A charge of €32 million arising from the workdown of acquired inventories remeasured at fair value. This adjustment has no cash impact on the Group.
- b) An amortization charge of €3,866 million against intangible assets. This adjustment has no cash impact on the Group.
- c) A pre-tax restructuring charge of €98 million.
- d) Impairment losses of €946 million, relating mainly to Ketek and Ramipril. This adjustment has no cash impact on the Group.
- e) The tax impact primarily comprises:
 - a. Deferred taxes of €1,888 million generated primarily by the amortization charge of €3,866 million taken against intangible assets, impairment losses on intangibles of €946 million, and the €32 million charge arising from the workdown of acquired inventories remeasured at fair value. This adjustment has no cash impact on the Group.
 - b. Reversal of deferred tax liabilities of €95 million due to the tax exemption of some internal capital gains on investments.
 - c. A tax saving of €33 million related to the €98 million of restructuring charges.
- f) In "Share of profit/loss from associates", a charge of €108 million corresponding to amortization and impairment of intangibles (net of tax) and the workdown of acquired inventories. This adjustment has no cash impact on the Group.

Appendix 5: Simplified consolidated balance sheet/consolidated statement of cash flows**Simplified consolidated statement of cash flows (unaudited)**

€ million	2006 full-year	2005 full-year
Adjusted net income	7,040	6,335
Depreciation, amortization and impairment of property, plant & equipment and intangibles	1,296	983
Impact of restructuring costs*, net of tax	(34)	(530)
Net gain/loss on disposals of non-current assets, net of tax	(558)	(125)
Other items	(134)	(26)
Operating cash flow before changes in working capital	7,610	6,637
Changes in working capital	(1,006)	(239)
Net cash provided by operating activities	6,604	6,398
Acquisitions of property, plant & equipment and intangibles	(1,454)	(1,143)
Acquisitions of investments in consolidated undertakings, net of cash acquired	(509)	(692)
Proceeds from disposals of property, plant & equipment and intangibles, net of tax	1,174	733
Other items	(1)	1
Net cash used in investing activities	(790)	(1,101)
Issuance of sanofi-aventis shares	307	314
Proceeds from sale of own shares on exercise of stock options	50	105
Dividends	(2,050)	(1,614)
Other items	14	174
Change in net debt	4,135	4,276

* relating to the Aventis acquisition

Simplified consolidated balance sheet

€ million

ASSETS	31/12/06	31/12/05	LIABILITIES & EQUITY	31/12/06	31/12/05
Property, plant and equipment	6,219	6,184	Equity attributable to equity-holders of the company	45,600	46,128
Intangible assets (including goodwill)	52,210	60,463	Minority interests	220	189
Non-current financial assets, investments in associates and deferred taxes	7,174	7,177	Total shareholders' equity	45,820	46,317
Non-current assets	65,603	73,824	Long-term debt	4,499	4,750
Inventories, accounts receivable and current financial assets	11,007	11,872	Provisions and other non-current liabilities	7,920	8,250
Cash & equivalents, short-term investments and deposits	1,153	1,249	Deferred taxes	9,246	12,208
Current assets	12,160	13,121	Non-current liabilities	21,665	25,208
Total ASSETS	77,763	86,945	Accounts payable and other current liabilities	7,833	8,995
			Short-term debt	2,445	6,425
			Current liabilities	10,278	15,420
			Total LIABILITIES & EQUITY	77,763	86,945

Appendix 6: Trends in selected adjusted income statement items (after tax)

€ million	Q4 2006	Q4 2005	2006 full-year	2005 full-year
Restructuring costs	(122)	4	(122)	(17)
Net gains/(losses) on disposals	106	34	553 ¹	135 ³
Provisions for financial instruments, litigation, tax inspections and other items	25	46	38 ²	50 ⁴
TOTAL after tax	9	84	469	168

¹ including:

- Exubera®: €384 million
- Rhodia: €101 million
- Animal Nutrition: €31 million

² including:

- tax exposures/settlement of tax disputes: €105 million
- impairment of Ketek® industrial assets: -€79 million
- CSL: €43 million
- provision for investment portfolio: -€26 million

³ including:

- Oral Health: €48 million
- Transkaryotic: €26 million
- Viropharma: €22 million

⁴ including:

- Bayer litigation: €41 million
- CSL: €34 million
- provision for investment portfolio: -€23 million

Exhibit DD



Rimonabant USA: Update

- Sanofi-aventis Acknowledges FDA Announcement of an Advisory Committee Meeting for rimonabant -

Paris, France, March 26, 2007 - Sanofi-aventis announced today the FDA notice for its first in class CB1 receptor antagonist rimonabant, now scheduled for an Endocrinologic and Metabolic Drugs Advisory Committee Meeting to be held on June 13, 2007.

The Committee will discuss the efficacy and safety of rimonabant in obesity.

Sanofi-aventis is pleased to have the opportunity to present its data on rimonabant and to exchange with experts.

About sanofi-aventis

Sanofi-aventis is one of the world leaders in the pharmaceutical industry, ranking number one in Europe. Backed by a world-class R&D organisation, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine and vaccines. Sanofi-aventis is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expect," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2005. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

Exhibit EE

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Event Date/Time: May. 03. 2007 / 2:00AM ET

FINAL TRANSCRIPT

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

CORPORATE PARTICIPANTS

Sanjay Gupta

Sanofi-Aventis - Head of IR

Hanspeter Spek

Sanofi-Aventis - EVP Operations

Jean-Claude Leroy

Sanofi-Aventis - EVP Finance and Legal

CONFERENCE CALL PARTICIPANTS

Tim Anderson

Prudential Securities - Analyst

Gbola Amusa

Sanford Bernstein - Analyst

Richard Woodman

APM Health Europe - Media

John Murphy

Goldman Sachs - Analyst

Amit Roy

Citigroup - Analyst

Michael Leuchten

UBS - Analyst

Michael Leacock

ABN Amro - Analyst

Sebastien Berthon

Exane - Analyst

Graham Parry

Merrill Lynch - Analyst

Paul Mann

Deutsche Bank - Analyst

Alexandra Hauber

Bear Stearns - Analyst

Jerome Berton

Aurel Leven - Analyst

Jo Walton

Lehman Brothers - Analyst

PRESENTATION

Operator

Good day, ladies and gentlemen, and welcome to the Sanofi-Aventis Group first quarter 2007 sales and earnings conference call. For your information, this conference is being recorded. At this time, I would like to hand the call over to your host today, Mr. Sanjay Gupta, Head of Investor Relations. Please go ahead, sir.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Sanjay Gupta - Sanofi-Aventis - Head of IR

Thank you, Claudia. Good morning, everybody. Thank you for joining us this morning. On today's call, the participants from Sanofi-Aventis will be Laurence Debroux, our CFO, Jean-Claude Leroy, our Executive VP Finance and Legal and Hanspeter Spek, Executive Vice President of Operations.

I would like to begin by just taking care of legal requirements. During this conference call, we may make projections and forward-looking statements, which are based on our current expectations, but actual results may differ materially due to various factors. For additional information about the factors that affect our business, kindly refer to our forward-looking statements on our 20-F.

The format of today's call will be the same as previously. We'll begin by a small presentation, which will be followed by a question and answer session. Mr. Spek will make a presentation on the Company's business during the first quarter.

Hanspeter Spek - Sanofi-Aventis - EVP Operations

Yes, good morning, everybody. Thank you for being with us so early today. Well, we [have] to report the first quarter 2007, which we consider to be a good quarter. Why? Mainly for two reasons. First, because it's in line, even a little bit reinforcing, what we have seen for the fourth quarter 2006. And second, because it shows a growth which is in line with pharmaceutical markets, even a little bit stronger.

Now, more in detail, if you go to our presentation page three, you will find then that the top 15 products have been growing in two digits by 10.5%. You see further and I will comment more in detail that the base business nearly has been stable. It's a small decrease of 1.8%, giving overall Pharmaceutical sales a growth of 6.2%. Vaccines continued to be a strong contributor to our growth with 16%, giving overall sales performance, then, a growth of 6.9%.

From a geographical breakdown, you see - and I believe it will be not a real surprise to you - that Europe has been difficult, with slightly negative sales growth of 1.3%, largely due to the situation in France and Germany - I will get back to this, of course, also, more in detail - but also to a new issue we had in Turkey, where we have been struck by reforms and by negative currency impact, which is a rather new situation but, for us, significant, given the importance we have as market leader in the Turkish market.

In contrary, very strong growth, 16.4%, in the United States. This is by far more than twice the market growth in the same period. And in the rest of the world, which will be definitely tomorrow our main marketplace, continued two-digit growth with nearly 11%.

If you turn to the following page, page four, then, you see the leading 15 products overall. You see, of course, again, those 10.4% in terms of overall growth. And now perhaps a little bit more in detail. Lovenox, a growth of 8.2%, which seems to be modest on first glance, if you keep in mind that the overall prescription growth is two-digit. So what happened there is a change in the ordering schedule of one of the major wholesalers. So we are totally confident that the growth in the second quarter will go back to two-digit.

The Plavix result, to be commented also in more detail, is of course under the influence of the appearance of the generic coming from Apotex in the second half of 2006. [Also there] more details, but [upfront] you see, if we take out already the sale of active ingredients for the United States to Bristol-Myers Squibb, corrected sales growth would have been 6.4%.

Very strong growth Stilnox, Ambien and Ambien CR. We will give you more information of this. In any case, the 49%, definitely spectacular. Taxotere, finally, I have to say back to a two-digit growth. I have [committed to] this for quite some time. I am happy to report that the first quarter growth now shows two-digit growth. I believe that we have a positive future ahead of us.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Eloxatin, negative, minus 3%. We will see in more detail the product is continually doing very good, very positive in the United States. But in Europe, we are now hit by the end of patent situation, which progressed during the first quarter, mainly in the United Kingdom and in Germany. In France, we still have no generic competition, but of course this will come during the year, [next month].

Lantus continues to grow extremely strong, given the level of sales - plus 27%. The product is now the more or less unchallenged leader of the insulin market. We are very content with the Copaxone performance, 17.5%, largely driven by newer data which has been published during the second half of 2006. Aprovel, 7.8%, I believe nothing in detail to be reported.

Tritace, minus 6%, a product which had lost its patent protection already during 2005, 2006, has now direct competition from generics in Canada. This was the remaining major market for this product. Allegra, plus 22%, largely driven by an extremely positive success of Allegra in Japan - and I will get back to Japan overall in a couple of minutes - but also supported by a continuous growth of Allegra-D in the United States.

Amaryl and Xatral are products equally struck by generic competition, Amaryl all over the world, Xatral, so to say, only in Europe. We are not content with the development of Actonel, which you see is minus 10%. Why? Mainly by appearing competition, indirect competition through generics for [fulcromas], which is the European market. And we have to see, together with our partner Procter & Gamble, how to better address the situation in the future. No further comments, then, to be made on Depakine and Nasacort from my side.

Now to page five, a little bit more in detail on a number of major products. I start with Acomplia. You see that, when you look at the headline, 130,000 patients already being treated in Europe. We continue to see an encouraging starting success. On the left side of the [slide], you see a comparison, for the 11 markets where the product has been launched, [inaudible] compared -- in comparison with the major and most successful launches from our competitors and you see that Acomplia behaves very well.

A little side note on a report you may have read in the press, which was referring to prescription data in the U.K., which are called PCA. The report, in short, said that the sales would be not satisfactory. I have to correct this. The report is stating only a selected part of the overall market, which is the NHS market inside England. So it's not reporting everything which happens outside the NHS market and outside England, which means Scotland, Wales etc.

We are equally content to report that we target very well our patient population, as you see from the right side of this chart. We have everywhere patients between 84 and 95% exactly inside our target group, which means with a body mass index superior to 27 and risk factors such as diabetes.

Nevertheless, on page six, we are very well aware of that the Acomplia battle will be long-lasting battle, driven by life cycle management and [step wise] improvement of reimbursement. We have encouraging steps and, most recently, are of course very happy to report the reimbursement we have obtained in France. It is too early to give very detailed data, but we tend to believe that we have a very, very good start also in France.

And in Switzerland we have obtained the reimbursement, which we consider, on the database we have as of today, as very positive, covering obesity alone and obesity -- or overweight patients which have an accompanying disease of diabetes. Our life cycle management is very well in place. You know that we have submitted Serenade to the authorities in Europe and the U.S. And we expect to hear from them, within the weeks or months to come, concerning our labeling.

Of course, the big event in context with Acomplia for the second, the ongoing quarter will be the FDA advisory committee planned for June 13. We are, of course, actively preparing for this meeting. We welcome the opportunity to show all our data and to discuss it in public. We believe that this, in fact, is the best way to find the right decision for this very important product.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

On page seven, then, Plavix. What you see is positive. It's very positive. It's encouraging. You see, in short, on the right side that, in terms of new prescriptions, the trademark Plavix, by the end of March, has been back to 90% of the previous market. This is perfectly in line what we see in terms of ex-factory sales, as you may have read in the publication of our partner Bristol-Myers Squibb.

The first quarter of sales increased to \$789m, after less than half in the fourth quarter. And this is a trend we continue to observe in the ongoing quarter, in terms of prescription, in terms of ex-factory sales. So we are convinced that the generic stock will be finally exhausted during the ongoing second quarter of 2007.

And then, if you turn to the next page, number eight, we believe that we have an excellent base for future growth. Why? Because the increase of the prescription for the total molecule, I believe, is spectacular, given the size of the product. As you see, the sales -- the prescription growth rose to 22%. We had reported, in the previous quarter, a number of organizational changes, new allocation of resources. And yes, finally, we also benefit from the relatively recent FDA panel on the Drug Eluting Stents, but not only - as you see on the lower part of the page, we finally also succeed in peripheral arterial disease, where sales very nicely increased to 35%.

An additional comment on Plavix in respect to Japan. We had a very slow launch of Japan with Plavix. We have given the reasons. There are a number of hurdles in place which limit prescription, which limit the number of patients. Those limitations have been lifted partially and what we see is a very, very consequent increase of sales every month.

And the last hurdle will be lifted now in the [ongoing] month of May. And we are developing increasing confidence in the situation of Plavix in Japan, also supported by the fact that we have taken back the rights of Panaldine, which means we are now in a better and stronger position to manage both molecules, ticlopidine and clopidogrel. And, as you have also noticed, we have terminated our promotional activities together with Daiichi. So overall, we are in a stronger, more direct position to manage both molecules in the best interests of the patients. So this gives us increasing confidence.

On the next page then, some information on Lantus. You see that the overall growth of 27% is a growth which is driven by all markets - the United States, Europe and the rest of the world. And then, on the right side, you see that Lantus by far is the leading insulin. You see also the development of the other products, which are either [decreasing] [inaudible] like premix or natural insulins. And you see then, also, the performances of the more recent launches, like Levemir and Byetta, which we consider as not impacting directly our performance, as it is obvious from this chart.

We believe that there is much more opportunity to grow with Lantus in the future and you see this more details, then, on page 10. There are new guidance, therapeutical guidance, for the use of insulin. And on the left side of the page, you see that, according to the most recent guidance, insulin, basal insulin, should be immediately added to the regime if lifestyle intervention and metformin have failed. And then consequently, on all three steps, insulin plays a leading role.

And we believe that [in] insulin, mainly given the significant advantage of easy dosing, that [within] Lantus has an excellent position. This is confirmed when you look to the right side of the chart, where you see that the usage of insulin in Type II diabetes patients is continuing to grow from only 40, 41% in October '05 to November '06 by 10 points, and consequently diet alone and the oral products are in regression.

We have further invested into the product, launching a new device. On page 11, you see picture of both devices, both devices for Lantus and Apidra. We could report that, before yesterday, that the FDA has registered Solostar. This is very encouraging news. The role of devices in the U.S. still is relatively low, but we believe this is a device, which we consider as being superior, [this will change], will give us additional opportunities. We have, as I said, invested into this program heavily. And we have internalized the production of devices to drive innovation and, of course, to better control quality of this very essential part of an overall insulin program.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

On page 12, some additional information on Lovenox. I have commented on the sales growth, which is a little bit [short of] [inaudible], but will be back to a two-digit growth during the second quarter. You see that the product, for us, remains an important product, also, in terms of life cycle management. We have excellent data, which will continue to drive this product. I believe, in a short term perspective, most important data will be ExTRACT. ExTRACT, in short, has reconfirmed the superiority of Lovenox over unfractionate heparin, which still represents about 60, 70% especially of the American market. So there's still a large room to grow and we are confident to do so.

Then, on the next page, 13, information on Ambien. Yes, the month of April saw the end of the patent protection for Ambien IR. This does not at all mean the end of the success story of Ambien overall. Why? In short, because we managed to drive Ambien CR being the leading brand in this market. You see on the chart on the left side that Ambien CR holds, currently, a market share of approximately 15%, as compared to 11% of Lunesta.

What we try to achieve is approximately 50% of sales. And I'm honest to admit that I would have preferred to have a higher [switch] rate than the 32% we have obtained by the end of the patent. But, in the same time, we succeeded to drive the overall family of Ambien products much stronger than we had anticipated when launching Ambien CR, which was in August 2005. You see that, if you annualize today Ambien CR sales on the right side of the chart, we are very close to have a new blockbuster in our portfolio, which will do everything to step into the shoes of the previous blockbuster, IR.

Now, first data to the market, we have to see this with extreme prudence, because we have nothing but one week. And this is daily prescription data, which is perhaps not the most reliable insight. That's the data we have access to. But what we see today is [similar] impact on the growth of Ambien CR, which is of course, today, our major objective in driving this product and we have concentrated, evidently, all our efforts on Ambien CR. And we have increased our investments in this transition period, especially in the field of DTC. So we are confident that Ambien CR will continue to make its way, being the leading brand in this very important market.

Page 14, as usual, short report on our activities for the base business. You know which importance we give to this base business, especially in the international [zone]. And, as you see, we've succeeded there to continue to develop this part of the business positively, with a sales growth of nearly 7%. In the U.S., the base business plays no role.

In Europe, we were a little bit suffering by 2.3%, which is driven by, I would say, two facts. First, yes, the intervention -- the continued intervention especially of the German and the French government hits those products, first because most of them are not patent-protected. Second, the negative sales development of Ketek, which is according to our in-house definition in this segment, so called base business, also contributed to the minus 2% for the first quarter inside Europe. But overall, if you will exclude Ketek, you see that worldwide sales of the base business are de facto stable with minus 0.4%.

I said in my introduction Vaccines continued to contribute strongly to overall performance and you find more details, then, on page 15. [Other facts] to be explained upfront is the development of influenza vaccines, with minus 17%. It is a seasonal thing. We have less [stockage], especially in the United States, to be reported for the first quarter. We are convinced that this will be equalized during the year. You see that, besides, boosters are growing extremely strong with 65% and meningitis and pneumonia with nearly 50%, so overall giving them those 16%.

Page 16 gives a short summary on, so to say, our part to be reported on Gardasil. You know that this is a product which has been invented by Merck. We share it inside our joint venture in 18 countries in Europe, where we contribute also promotional resources from our pharmaceutical activities to this joint venture. And Merck, with its pharmaceutical [resources], is doing the same.

We see a good beginning in Europe with Gardasil. We progress step by step. And you know that, as with any pharmaceutical product in Europe, the market is largely depending on reimbursement, where we continue to progress, where we have very encouraging news in terms of reimbursement coming from France, but also from Italy and partially from Germany.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

To close on my part, here you find on page number 17 some information concerning business development. We have been challenged in this respect during recent quarter presentations. So as you see, we have concluded a number of agreements, which we consider as being very promising. This is true for Pharmaceutical products. It's equally true for Vaccine products.

And last but not least, we widen our economic presence in Japan. We have taken back the rights of Acomplia, Plavix, Panaldine. We are in the process of concluding other agreements in the same direction. So we believe that, overall, the two-digit growth you have seen in the first quarter in Japan will continue by internal growth, first of all, and [within] of course Plavix plays an important role but not only, because also because of external growth.

So to sum it up, we see a first quarter which is perfectly in line with our previous results for the end of 2006. It is clear that 2007 in the second quarter will become a little bit more difficult, because of the out of patent situation with Ambien IR. But as said before, we believe to have, with Ambien CR, a strong growth driver to maintain our market leadership in this market segment in the United States. And saying so, I pass on to Jean-Claude Leroy.

Jean-Claude Leroy - Sanofi-Aventis - EVP Finance and Legal

Thank you, Hanspeter, and good morning, everybody. I propose, as usual, that we keep an eye on page 18 and 19 and then we skip through the next pages to our comments on the P&L of this first quarter.

First, all of you know that, talking from a comparable basis growth of 6.9% on the sales, we are posting 2% growth on a reported basis, mainly because of the currency impact. And as you can see, this is a 4.6% decrease that we are posting this first quarter, two-thirds of which being the U.S. dollar parity evolution versus what happened in the Q1 2006, namely the parity to the dollar was 1.20 in the first quarter of 2006, when it was 1.31 in the first quarter of '07.

If we go down to the gross margin, you see a stable ratio to sales, 17.7 -- 17.6% -- sorry, 77.6%, as in the first quarter of '06. This is due to two factors going different directions. First, there is an improvement of 0.5 -- of a point -- 0.5% of a point to 26% of the cost of goods to sales ratio and this is totally due with the favorable product mix. You've seen that the first [inaudible] fifteen products grew 10.5%, which is obviously higher than the global portfolio. So this explains this improvement in the gross margin and, I should add, despite the fact that most of our production are in the euro zone.

The other way, in the other revenue, there is a small decline versus Q1 '06 and this is mainly due to two factors. The first is a small diminution in Q2 [of] Plavix in the U.S. And you've seen the figures from Hanspeter's presentation. And the other one is the discontinuation of the royalty income coming from Merial on Fipronil. This was, by contract, ending at the end of 2006. Obviously, losing that, say, 100% revenue, we recouped 50% of it, because through our consolidations, through the equity method, 50% of Merial net income, we are recouping half of what we lose on this line item.

If we go down to expenses, now, I guess that is where we see the main evolution, an evolution which, in a sense, is in line with what you've seen during the fourth quarter of 2006, which is a close monitoring of the expense. Even though through these figures, you can imagine that there is currency impact, but that's not all of the explanation.

Just to give you a comparison, you see R&D growing by 3.3%. At the end of the day, when we do that on a more comparable basis - I'm talking of currencies - I can tell you that we posted a 7% increase of these R&D expenses, excluding this currency impact.

The next item, which is Selling and General expenses, is probably the one where we see the most important impact, since we are diminishing by 8.6% during that first quarter. And I can tell you that the exchange effect is by far not the only explanation. The real explanation of this trend is the continuing adaptation of the measures we've taken after, you will remember, August 31 of '06. We've seen that through the end of the third quarter, continuing in the fourth quarter. And obviously we are continuing monitoring the expense during this first quarter of '07.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

You see the result of all of that through the operating income current, which, by reaching EUR2.7b in this first quarter, is showing a 3.5% increase in the ratio to sales, coming from 34.4 up to 37.9%, and showing a 12.4% increase, which is directly to be compared to the 2% increase in net sales, reported sales.

Going down to the second part of the P&L now, what do we see? A small amount in this quarter which is the continuation of the impact of the restructuring plan in France, with this EUR22m. And the other important item which is to be compared with were these gains we made last year under sales, the disposal of Exubera to Pfizer, which was the main item. And the second one which was the Nutrition business we disposed of the remaining 30% stake. Obviously, this year, there was no such main disposal. So the calculation, when it comes to the operating income level, is a little bit more difficult to read. But then I will be back later on the results before selected items for a better understanding.

Going down to the net financial expense, let me tell you that within these two amounts '07, '06 of close to EUR30m, you see an interest charge which is decreasing to EUR56m, coming from EUR73m in the first quarter of '06. And this is definitely due to the reimbursement of debt we were able to achieve during the first quarter, as well as a reverse effect because of the increase in the interest rate in the euro zone as well as in the dollar, when you compare these two quarters.

Now, the next line item, which is income tax, deserves a special comment, since you can see that the rate which is posted - 22% in Q1 '07 - is not the usual tax rate, as well as it was not the one with 28%. It was the same situation in the first quarter of '06. Now, you would remember, in '06, we had that disposal of Exubera I was just mentioning before, with a low income tax [attached]. So you may remember that, last year, we had an effective tax rate, excluding this kind of special item, of 30.7%.

Now, I can tell you that, in the first quarter of '06, we also had same 30.7% effective tax rate, the difference being a net profit of EUR223m, which is the result of the net of reversal of provision for tax risks and resolution of tax audit. And definitely that's the last part of this sentence, resolution of tax audit, which is the reason for this big profit of more than EUR200m in this line item.

Going down to the share of profit and loss from associates, not that many comments. And it was mainly -- The difference comes from the consequences of the sales of Plavix. And now, in the U.S., unfortunately, we are talking of the conversion in euro, so even though the decline in sales between the two quarters were rather slow, as Hanspeter showed to you, when it comes to conversion to the euro, it adds up a negative impact. And minority interests, the other way around, are increasing simply because the management of Plavix and Aprovel in the rest of the world, the part which is managed by Sanofi-Aventis, is improving.

I said that, page 26, we would give a word on selected items, which are of so much importance for the better understanding of the performance. As you can see, in '06, mainly gain and loss, mainly gain on divestment, and I was mentioning Exubera and Animal Nutrition. In this first quarter of '07, mainly provision for tax and resolution of tax audit, this EUR223m profit I was mentioning.

So for this good reading, we would have to exclude [EUR200m] of profit in the Q1, when we have to exclude EUR466m [out] of the 2006 first quarter profit, which three drivers to report on this adjusted net income before excluding selected items. And as you can see, starting from an adjusted net income which is posting down 3.1% at EPS level, when we exclude selected items, we are showing an EPS of EUR1.41 per share, which is up 11% as compared to last year.

I said that we were continuing to reimburse our debt. This is shown in slide 28, where you can see that the first quarter generated a net cash flow of EUR1.8b, the same amount as we did last year. And obviously the gearing of the Company is below, now, 10%.

This very good performance we had during the quarter, the first quarter, drove us to increase, to raise, our yearly adjusted EPS growth guidance. And we have decided to increase this guidance by 3% for the full year, bringing it from around 6% to now around 9% expected growth for the full year. Now, obviously, this is calculated by keeping the same exchange rate, the same parity between euro and dollar, which is the 1.25, you may remember, which is the average of 2006.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

So to -- If I may summarize in a few words this first quarter performance, I would insist on three items. The first is the good leverage of the P&L through continuous close monitoring of the expense, driving an improvement of the operating income current of 12% and bringing it at 38% of sales.

Second, I would mention that EPS before selected items increased, up 11%. And let me tell you that it would have been even plus 17.6% at constant 2006 dollar euro parity, which is probably a better way to compare with peer results mainly denominated in U.S. dollars. And therefore we can post -- trust in our '07 performance, which led us to increase this expected growth of EPS by 3 percentage points, as I just mentioned.

Thank you very much and now the floor is yours.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Claudia, can we open it up to questions, please?

QUESTIONS AND ANSWERS

Operator

Thank you. Ladies and gentlemen, the question and answer session will be conducted electronically. [OPERATOR INSTRUCTIONS]. We will take questions in the order received and we will take as many as time permits. [OPERATOR INSTRUCTIONS]. We now move to our first question from Tim Anderson with Prudential Securities. Please go ahead.

Tim Anderson - *Prudential Securities - Analyst*

Thank you. A couple of questions. Eloxatin in Europe is facing some generic competition in the U.S. Realistically, when might we expect generics to launch and how comfortable are you with your intellectual property on that product in the U.S.?

And then, second question is just an update on Lovenox generics. Can you comment on your degree of confidence that FDA will not approve AB-rated generics against the product either this year or next year?

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

Well, Tim, let me start with the FDA. So I think you phrased your question very prudently, because you said what is the degree of confidence. So we are talking, really, about something which is today not material. But nevertheless, what we see, if we look to the recent events during the first quarter, we understand there is a trend in the sense that the U.S.A. starts to tend to follow the European attitude concerning biosimilars.

And the European attitude is clear. It is fixed. It has been expressed by the EMEA, saying that biosimilars or bioequivalent products need to show clinical proofs that they are really therapeutically equivalent. And we believe that this, for the time being, is best reflected in the outcome of the Congressional hearing and in a paper Senator Kennedy has issued later, in which he says he believes that biologicals should prove to be equivalent not only in terms of pharmacokinetic data but also in terms of clinical data.

And what we tend to understand is that this is something which generic companies also start to incorporate into their strategy. So once again, this is what I tend to believe today. There is nothing really material coming out of the FDA, besides the fact that

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

several people outside the FDA have expressed themselves in the same direction. I hope this is satisfying for you, but I cannot give you more.

Now, on the protection of Eloxatin in the U.S.A., please remember that ANDA can only be filed after data exclusivity has expired. In the case of Eloxatin, this was extended six months to February 2007. And as of today, we have not received any notice of certification from a generic competitor to date. Independently, the ready to use form approved and marketed in the United States is covered by patents running as late as 2015. And yes, we feel very comfortable in the respect of Eloxatin's protection in the U.S.A.

Tim Anderson - Prudential Securities - Analyst

Thank you very much.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Can we have the next question please?

Operator

We move to our next question from Gbola Amusa with Sanford Bernstein. Please go ahead.

Gbola Amusa - Sanford Bernstein - Analyst

Hi. Thank you. Good morning. Gbola Amusa at Sanford Bernstein. I have three questions on Acomplia, the experience in Europe. Your internal data, first of all, are showing that 90% of Acomplia patients have risk factors. What is the average number of risk factors for those patients? Secondly, of those 130,000 EU patients, what percent are paying out of pocket?

And then lastly, it's perhaps a bit too early for this question, but maybe you have some data from the U.K. I'm just wondering what the drop out rates for patients on Acomplia are and if that's influenced by reimbursement at all.

Hanspeter Spek - Sanofi-Aventis - EVP Operations

I'll start with the last of your three questions. The drop out rate we see is significantly lower than what we see in the clinical trials. So you remember that the drop out rate in the clinical trials has been between 40 and 50%. Now, let's keep in mind we are not in a comparable situation and the quality of data we have necessarily is also not comparable, because in [inaudible] clinical trials, of course, the quality is higher. Nevertheless, what we see is significantly lower and I would estimate it between 20 and 40%, depending on the market and depending on the reimbursement situation.

This leads to your second question. What we see as of today is that approximately 40%, in average, pay for the product out of their own pocket. Now, again, we have to read this with care. We have nearly 100% reimbursed patients, let's say, in Scandinavia, where we do, by the way, extremely well in Sweden. And of course we have today zero, or close to zero, reimbursed patients in Germany. So the situation varies strongly, but, as an average for the 10 or 11 markets I gave you in my presentation, 40% is a good estimate.

Then, last, on the accompanying risk factors, they vary between two or three and [they are] the classicals you may expect - first of all, diabetes, second, dyslipidaemia, and third, hypertension.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Gbola Amusa - *Sanford Bernstein - Analyst*

Thank you.

Operator

Moving to our next question, Mr. Richard Woodman with APM Health Europe. Please go ahead.

Richard Woodman - *APM Health Europe - Media*

Good morning. Do you still see a certain logic to a merger with BMS?

Jean-Claude Leroy - *Sanofi-Aventis - EVP Finance and Legal*

As you know, we've been constant in our answer. We don't comment on this. And I'm sorry to be consistent with what we've always said on this kind of subject.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Thank you. Can we have the next question please?

Operator

Thank you. The next question comes from John Murphy with Goldman Sachs. Please go ahead.

John Murphy - *Goldman Sachs - Analyst*

Yes, good morning, gentlemen. Hanspeter, could you tell us, please, if you had any pricing benefit at all in the U.S.? And Jean Claude, a couple of questions, please. First, any stand out or sizeable components in the other operating income line of EUR191m?

And second, you talked about continued close monitoring of expense and we certainly saw that with a very strong performance in SG&A in the first quarter. Can you maybe talk a little bit more about the moving parts of this line item going forward? I'm wondering really how indicative the first quarter may be of the full year performance here.

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

John, so I start with the pricing policy. Overall, we have increased our prices as usual during January, with two exceptions. We had a very small price increase in March for Taxotere of 1.5%. And we had a price increase for Ambien, given the out of patent situation, of course, of 9% in February, which means we have driven up the prices of Ambien IR in respect to two references.

First, of course, the reference Ambien CR. At the moment when patent went off, Ambien CR is significantly lower priced than Ambien IR. And the second reference for our pricing policy, of course, has been Lunesta. And we are positioned today that we are approximately 10% less expensive - I'm talking on a [VAT] basis - than Lunesta with Ambien CR.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Besides this, our price increases in January have been, with some exceptions, in the neighborhood of 5%. This is true for Lantus, Lovenox, Actonel, Apidra, Avalide. Avapro has been slightly above 6.9%. Copaxone, we took a price increase of 9.9%, given the competitive environment.

John Murphy - *Goldman Sachs - Analyst*

So it would be fair to assume sort of mid single digit benefit in terms of pricing in the U.S.

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

Excuse me, I didn't understand you [phonetically].

John Murphy - *Goldman Sachs - Analyst*

So it would be fair to assume that, within the U.S. growth, there will be at least around about four or five points of pricing.

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

For the overall year, yes.

John Murphy - *Goldman Sachs - Analyst*

Thanks.

Jean-Claude Leroy - *Sanofi-Aventis - EVP Finance and Legal*

Okay, move to next question. First, the other current operating income and expense, I have to mention that there is a slight change between '06 and '07 in the way to book a certain income and expense. Now, upon the recommendation and, I have to say, the recent request and recommendation of IMF in France and SEC in the United States, we've been obliged, as other companies, to change [only] the posting of some [inaudible] some charge and profit, in the sense that, now, within the three following line items, such as restructuring costs, impairment of PP&E and intangibles, gains and losses on disposal and litigation, we can only report significant amounts, which is a difference with the past, where there was a possibility [inaudible] to report each and any amount in the same area.

The difference it makes between the two quarters is such that we've had some minor [operations], like some small disposal and gain on disposal of assets, some small amount of litigation which had solutions during the quarter, which were posted above the operating income current line item, namely in this other current operating income and expense line item, where it was posted below.

Now, to make this as clear as possible, I have to confirm to you that, first, any of these --- each and any of these items are small. And then, when you take the [full average], you make the addition of the plus and minuses, this comes to a very insignificant amount when it comes to make the comparison between this and the result for even the operating income at current. So yes, a minor change in the presentation, but which has no influence in the reading of the performance of this first quarter of '07.

Your second question is related to the trend in the expenses. Well, once again, I suspect that I can say that, indeed, when it comes to R&D expense, you know that we don't monitor R&D expense lines. We spend the money which is necessary to go on

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

clinical trials when they are ready to be made. And on the other line items, fair to say that there has always been room for monitoring of the level -- of the global level of expenses of the Company in the selling, SG&A line item.

Now, I am not very much in favor of giving you too much, too many precise figures. [Say] that we are not going to [inaudible] trend, the trend but not the figures, up to the end of the year. And this is one of the -- I mean, what you've seen during the first quarter, this rather important decrease, is one of the reasons for which we were capable of raising our EPS guidance for the full year.

John Murphy - *Goldman Sachs - Analyst*

Thanks very much indeed.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Claudia, the next question please.

Operator

Thank you. From Citigroup, we move to Amit Roy. Please go ahead.

Amit Roy - *Citigroup - Analyst*

Hello. Thank you. Amit Roy from Citigroup here. Just three questions. Firstly, on the Plavix litigation, I just want to make my understanding clear. If the judge rules in favor of Apotex, would they be allowed to launch at risk before any decision from any appeal that you'd carry out, firstly? And secondly, is there any update on the timing of that?

The second question surrounds the advisory panel on Acomplia. I see the title of the advisory panel includes the usage for obese patients, i.e. BMI of greater than 30, as well as BMI of greater than 27 plus a risk factor. Is that indicative of a use of rimonabant in the U.S. for just BMI of 30 alone?

And my third question is a small one. The trade name Zimulti that's mentioned on the advisory panel, is there any reason for the change from Zimulti to --- from Acomplia? Thank you.

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

I'll start on Zimulti. Zimulti is a request by a subdivision of the FDA which is in charge of trademarks. This subdivision is challenging trademarks from several angles, from a consumer angle in general. And this division considers that Acomplia could be too descriptive or eventually misleading, indicating that a patient taking Acomplia would accomplish his [inaudible] [target].

To give you another example, we had a similar case some years ago, when we tried to register irbesartan in the United States under the trademark of Aprovel, where the FDA indicated that they thought Aprovel would be too close to approval.

So it has, in short, nothing to do, absolutely nothing to do with the medical, clinical evaluation of the product. There were reservations from the FDA from the aspect I've described. And then we commonly decided on Zimulti. We had proposed others trademarks and the FDA agreed finally on Zimulti. So that's all for this.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Now, as far as the headlines of the commission or the advisory panel are concerned, we are not in a position to make any conclusions the way the FDA has set up this. And my only advice would be to be extremely prudent to [interpret] it too much into what you can read today on the web of the FDA in this respect.

Jean-Claude Leroy - Sanofi-Aventis - EVP Finance and Legal

On the U.S. Plavix situation, now, I will try to answer your question, even though your assumption is not one we favor. And I would observe that, if there was a negative outcome of the trial for us, it is likely that a generic would be re-launched, if I could put it this way, even though of course we would consider our own legal actions at that time.

As far as the agenda of the trial is concerned, as we've already said, there is no official agenda in such a trial. So we -- Again, sorry to repeat, but what we've observed in similar cases is that it takes generally between three and nine months between the end of the trial date and the date the judgment is rendered. So that's the best we can imagine. We have no other clue of this [actual] date.

Amit Roy - Citigroup - Analyst

Thanks very much.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Next question, please.

Operator

Thank you. We move to --

Amit Roy - Citigroup - Analyst

You answered two of the questions, clearly.

Sanjay Gupta - Sanofi-Aventis - Head of IR

I'm sorry, Amit, do you have another question?

Operator

Pardon the interruption. Mr. Roy, have your questions been answered?

Amit Roy - Citigroup - Analyst

Yes, thank you.

Operator

Okay. We now move to Michael Leuchten with UBS. Please go ahead.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Michael Leuchten - UBS - Analyst

Yes, just going back to the SG&A line, would you be willing to quantify the currency impact benefit that you experienced on the SG&A line?

Jean-Claude Leroy - Sanofi-Aventis - EVP Finance and Legal

Well, what I can tell you is that, starting from the decrease of 8.6% of this line item on a reported basis, with a constant U.S. dollar euro parity, the decrease would be in the order of magnitude of between minus 4 and minus 5%.

Michael Leuchten - UBS - Analyst

Thank you.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Next question, please, Claudia.

Operator

Thank you. We move to Michael Leacock with ABN Amro. Please go ahead.

Michael Leacock - ABN Amro - Analyst

Thank you very much for taking my question. Just on your adaptation program, I wonder if you could just give us a little bit more comment, perhaps, on your progress there, what you've achieved in terms of headcount reduction and savings, and perhaps a little more about the overall timing and scale of that program.

Jean-Claude Leroy - Sanofi-Aventis - EVP Finance and Legal

[Inaudible] I am not back to what we could call the French program. Remember that we posted, at the end of the year, a reserve for this program, which is mainly early retirement program plus some part which is dedicated to volunteer departures. This started really after negotiation at the beginning of the year.

You've seen that we posted an additional reserve in Q1. I can tell you that there will be another small amount in Q2, when -- because the rules in accounting is that you can only post when decisions are firmly made by the people. So we will see the impact of this French restructuring plan mainly a bit during the second quarter and definitely in the second half of '07.

For the rest, there is not something spectacular to announce, except that we go on monitoring, managing. You've seen that, when it comes to external forces [inaudible], when we consider that we have to do something, we take them out of the Company, which means that that's the explanation for which you saw so quick and rapid decrease in the SG&A line, even during the fourth quarter of '06.

[Say] that we are continuing to adapt mainly in Europe and for parts of the States when necessary. You've seen that, now, the States are back to a good situation of the sales of the main products. And that we do, I have said, to the contrary in the international zone, the rest of the world, simply because, as you've seen, we've been able to post very interesting growth in these areas. So

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

we go on sustaining this growth by feeding with the necessary promotional efforts in order to keep the kind of pace we've been seeing in these areas for over a year, now, a very interesting one.

So again, a dedicated and targeted not program but adaptation, here and there, when we feel that there is a need, because the measures taken by the authorities have [altered] very much the business of the Company.

Michael Leacock - *ABN Amro - Analyst*

Thank you very much.

Operator

Thank you. We now move to Sebastien Berthon with Exane. Please go ahead.

Sebastien Berthon - *Exane - Analyst*

Could you tell us what are the financial [inaudible] impact ---

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

Sebastien, we don't hear you at all.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Hello, Claudia, [are you on] the line?

Sebastien Berthon - *Exane - Analyst*

Hello, can you hear me?

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

Yes, that's much better.

Sebastien Berthon - *Exane - Analyst*

Okay. Hello, gentlemen. I was wondering what are the financials behind your giving back the rights on Alvesco to Nycomed. And also, could you update us on the situation for this product and the situation for the combination product with formoterol in the U.S. please.

Jean-Claude Leroy - *Sanofi-Aventis - EVP Finance and Legal*

As you may remember, this is an association with, now, Nycomed, which belonged to the legacy Aventis. We decided to withdraw from the mono form of the product and it has no other consequences than to stop the ongoing program with a six months period. And then we still go on on the combo form, and I mean by that that we're keeping the pace in the co-development of the program with a view to launch this product if the trials are positive.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Hanspeter Spek - Sanofi-Aventis - EVP Operations

Perhaps I may add two thoughts to this. The first one is that, prior to the acquisition by Nycomed, Altana had decided to withdraw from the co-promotion of the product as a mono product in the United States. And this is a policy which, overall, seemed to be confirmed by Nycomed, which has clearly communicated that they see no priority strategically in the United States.

The consequence would have been that we launched mono alone. And given the market, which is a market which clearly goes -- more than clearly goes into combo products, we have decided, then, to refrain also from launching the mono product in the United States. Having said so, it is clear that we maintain our interest into the combi product, which, in terms of development, is several years behind the mono product.

Sebastien Berthon - Exane - Analyst

Any financial impact from this settlement?

Jean-Claude Leroy - Sanofi-Aventis - EVP Finance and Legal

No, no impact.

Sebastien Berthon - Exane - Analyst

Thank you.

Operator

Thank you. We now move on to Graham Parry with Merrill Lynch. Please go ahead.

Graham Parry - Merrill Lynch - Analyst

Good morning and thanks for taking my questions. Starting off on Ambien CR, I was wondering if you could give us an update on formula repositioning, in particular what proportion of lives you have covered compared to proportion of lives covered with the IR version, and how much of the CR coverage is in tier two. Also on the Ambien IR, did you see a significant reduction in rebates in the first quarter as well as price increases helping sales for that product?

Then, moving on to flu vaccine, just wondering if you can give us an update on capacity and pricing trends for the '07, '08 season. It may be a little early, but hopefully you'll have some view on that by now.

And then, just finally, on SG&A, just could you give us a little bit more clarity on the cost reductions, particularly from a geographical point of view? So are we really looking at Europe still being the key driver of reductions here? How much of this is rep reductions versus different selling techniques?

And then, looking into the future quarters, should we be expecting to see a significant up-tick if you can launch Acomplia in the U.S.? Or do you still believe you can launch Acomplia using existing resources such as transitioning Ambien reps on to the product? Thank you.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Hanspeter Spek - Sanofi-Aventis - EVP Operations

So if you like, I start with Ambien CR. Now, the Ambien CR situation is extremely dynamic, because everybody, of course, was waiting for the very, very last minute. So what I report is what we have according to [mainly media] information as of February 2007. So in February 2007, 76% of lives have tier two and tier three access to Ambien CR. Approximately 20% of HMO, PPO and [DOS] total lives are enrolled, which is approximately 170m lives have tier two access.

We see a very, very strong progress in the overall access period and we have gained, during the last days and even hours, a number of very, very important accounts. There, of course, the purchasers also waited until the very last minute to see how things would go. So overall, we are very content with this. We have made no major changes in our overall commercial policy before the end of the patent protection for Ambien IR, except those which I described earlier concerning price.

Sanjay Gupta - Sanofi-Aventis - Head of IR

[Inaudible] vaccines?

Hanspeter Spek - Sanofi-Aventis - EVP Operations

Sanjay, yes, [if you could take] the vaccine question.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Essentially, the Q1 2007 sales are lower than the 2006 sales, but this is not because of any pricing impact whatsoever. In 2006, the CDC has placed an order for vaccine, [tactical] flu vaccine stockpile of about \$24m, and they purchased only \$10m in 2007.

So in 2006, Sanofi-Aventis supplied 170m doses, out of which 55m doses were for the U.S. In 2007, we forecast to supply about 200m doses. And so far, we have not experienced any pricing erosion for seasonal flu vaccines. So I cannot speak about the 2007, 2008 season now - we shall comment upon it later. But in our experience up to date, we have not seen any pricing erosion.

Hanspeter Spek - Sanofi-Aventis - EVP Operations

Now, the question on economies or synergies, it's a little bit difficult to answer and I don't want to give you a precise dollar or euro answer. But what did we do overall? Overall, our [progress on] worldwide is stable. But what we did [change is] we have reduced in the United States, in France and in Germany and we have increased approximately the same number of people, which is approximately 2000 people, in the fast-developing segments, which are of course Asia Pacific, to a lesser extent Japan and South America.

What we reduced in the U.S. is G&A, where we have made significant reductions beginning of 2006 and we continue to do so. What we have kept stable is the number of reps in the United States. Where we have reduced in Europe is, in contrary, largely sales force, but not only. We have made reductions in general administration. In our French subsidiary we are in the progress of reducing significantly our headcount in terms of sales force in Germany and in France once again.

So overall, it's a balancing effect. But as Jean-Claude has indicated earlier, we reduce [further] where we see less opportunity and we increase where we see continued an increase in opportunity.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Graham Parry - *Merrill Lynch - Analyst*

And on Acomplia launch impact in the U.S. on potential SG&A expenditure, do you still think you can transition using the existing resources that you have, or would you need to be looking to hire again?

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

From what I see today, I maintain this position, and once again the most important element in this game is the timing of the availability of Acomplia - which, if things go fine, should be in the second half and probably more in the fourth trimester than in the third trimester - and the continued development of Ambien CR. If what I indicated earlier, which is that we see no impact -- no negative impact by the out of patent of Ambien IR and CR, is being maintained, we will reduce our forces on Ambien CR when we have successfully managed the transition. This should coincide with the availability of Acomplia.

But you see, overall, we have about 7,000 reps in the United States, so we have a lot of opportunity to do. And if we would need, even short term, let's say, another 400 or even 800 people, we can do so relatively easily with external sales forces, which are available and which are of, in general terms, good quality.

Graham Parry - *Merrill Lynch - Analyst*

Thanks very much.

Operator

Thank you. We now move to Deutsche Bank, Mr. Paul Mann. Please go ahead.

Paul Mann - *Deutsche Bank - Analyst*

Thanks very much. Yes, I've got a couple of questions. Just looking at the Lantus, the new pen you're launching, could you talk just about the pricing premium of this pen versus, say, the [syringe and] vial formulation? Also, what proportion of your current revenues are sold in a pen? And what proportion of U.S. insulin prescriptions are sold in a pen, maybe giving some color on disposable pens versus, say, fixed pens? And also, do you have a target of what percentage of your current Lantus patients you hope to shift on to this pen? That's my first question.

Second question is on Plavix. I believe you said, about 12 months ago, maybe nine months ago, that you don't expect to achieve a similar price in Plavix in the new environment versus, say, the old environment. Perhaps you could just update us on where the price of Plavix is or where your realized price of Plavix is compared to, say, 12 months ago?

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

Let me start with the Plavix situation. Overall, we have a very homogeneous pricing for Plavix in the world, with a significant difference, of course, between -- of course -- still, of course, between the United States and the rest of the world, so to say.

The United States, as usual, are superior to the rest of the world. The rest of the world average price [I would see shape] today at approximately [EUR1.60]. And this is true for Europe and, of course, it is true for Asia. In Japan, we have a price which is approximately between [EUR1.80] and [EUR1.90], so it's superior, evidently. And in most Asian countries the price is between [EUR1.60] and [EUR1.90].

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Now, perhaps you are alluding to the recent discussions we have with the government of Thailand, where we evidently became under pressure, given the fact that, in an economy like the economy of Thailand, unfortunately, not everybody can afford to have this product at such a price. To stay in this example, today about 25 to 30% of the population have access to Plavix.

We have signaled to the government of Thailand that we understand their concerns and that we are open to go into special programs. And we get first signs from the Thailand government that this is being appreciated and we have to finalize, if possible, this in the upcoming weeks.

But overall, once again, we have a very homogeneous price policy for Plavix all over the world, if you accept that they are two parts, the United States and outside the United States. And we have not made any significant concession in this respect since the launch of the product.

Now, the question on the pen is really a difficult one, because there are very, very different usages from market to market. First of all, there are markets where the pens are being sold. They are usually being sold at cost and they don't present a real economic interest in this respect.

There are other markets, especially in Europe, where the pens are given away for free. So, yes, they are a burden for the overall presence in insulin, but they are very, very important element in the competition. And so, if one of the leading competitors, historically, has started to give the pens away for free, the others usually follow, for reasons which I believe are evident.

Third, there is a strong difference, then, in terms of usage. In the U.S., only approximately 10% of insulin patients are using a pen and this is exactly what we have for Lantus. But there is a new trend, then again, which, for Apidra, for example, which is a rather small product -- still rather small product in the U.S., pen users are about 40%.

Why? Because I believe the usage of a product like Apidra is very different. You inject it once. You inject it during meal time. So you are in a different situation as a patient and you appreciate to have a pen with you, while, when you inject your insulin at home in the morning and in the evening, you can do so more easily with cartridges.

So, to sum it up, there is no really homogeneous situation for the pens all over the world. In general terms, it's fair to say that they present no direct economic interest. They are a service product and we think they are very significant in terms of importance for the pharmaceutical product which is manufactured with it.

Paul Mann - Deutsche Bank - Analyst

So just to confirm, you don't expect to get a pricing benefit from launching your new pen over, say, a syringe and vial, which is where the bulk of your Lantus revenues are at the moment?

Hanspeter Spek - Sanofi-Aventis - EVP Operations

Definitely no.

Paul Mann - Deutsche Bank - Analyst

Okay. And then, just to confirm, on the Plavix, you didn't really talk much about the U.S. market, which is where I'm more interested in. What's the price of Plavix now in the U.S. that you're selling versus, say, 12 months ago?

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Hanspeter Spek - Sanofi-Aventis - EVP Operations

Well, you see, I think that this is premature to answer to your question, because I believe to understand that the background of your question is has there been an impact from Apotex generic on our prices. We believe that this is still too early, as there is still some stock [outside] in the market. We see pressure. We see requests to make concessions to get back to previous [second tier] positions. We resist for the time being. We tend to believe that we will have to make concessions, but it is still too early to give you precise figures in this respect.

Paul Mann - Deutsche Bank - Analyst

Okay, thank you very much.

Operator

Thank you. We now move on to Alexandra Hauber with Bear Stearns. Go ahead.

Alexandra Hauber - Bear Stearns - Analyst

Thank you very much. I've just got four questions. Firstly, you said earlier, initially, that, of the top line effect from the currency, two-thirds was from the dollar. Is there any -- Would it be wrong to assume that, therefore, the effect from the other currencies on your SG&A line would be different, so, if the dollar effect was 3 to 4% on SG&A, the total currency effect would be 4.5 to 6%?

Second point is a follow-up question to earlier. I think, Hanspeter, you said that -- if I understood you correctly, that there will be a transition period for Ambien CR where you keep the current promotional effort. And then, depending on how it plays out, you will allocate that to Zimulti. And from the timing, should we therefore assume that about -- in a period of three to four months you would see how the Ambien CR market would play out, because that would be the timeframe when ideally you make that resource reallocation decision?

And then a quick question on Eloxatin in Europe. From the -- Is the figure we see now a new run rate or is it still declining? You have obviously a much better visibility month on month. Any color on that?

And then a very quick question on Clopidogrel script acceleration. Is there any? Have you done any work at all to be sure that this is not related to the availability of cheap Clopidogrel? Looking from the recent trend, it doesn't seem to me to be particularly [void], because you would have [seen this] to level off, but have you done any work on that at all? Thank you.

Hanspeter Spek - Sanofi-Aventis - EVP Operations

So I try take the first three, which gives time to Jean-Claude to calculate the currency effect. Clopidogrel, yes, I believe, frankly, that there is some impact from cheaply-available Clopidogrel, but what we have in terms of figures indicates that it is minor.

There are a number of other elements which we believe play much stronger, which is first of all the readjustment of our promotional resources, especially to hospitals, where cheap Clopidogrel did not play any role, I dare to say. Second, we have, during the appearance of the Apotex generic, not at all reduced our investment. We even have accelerated in our investments, which means we have spent more in the second half of 2006 than in the second half of 2005.

Third, what we see in PAD is definitely a fruit of our continued investment into this otherwise relatively difficult field of indications. And lastly, the communication of the FDA concerning Drug Eluting Stents once again placed, so to say, only in favor of Plavix, because Clopidogrel as a generic has not been really present in the [stents room]. But I believe, yes, with the average [GP] there was a little positive effect and, yes, we have to do them, as we say, to keep this.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

On Eloxatin, very difficult to say what are a little bit the facts behind what you see today. We have a different impact from market to market concerning price. We see a main competitor, which is [main], which is the most aggressive what we see as of today in terms of price policy. And we see prices which are up to [50%] lower than the previous Eloxatin prices from us. Nevertheless, through our own measures and our own price flexibility in all markets, we maintain volume of 70, 80% in the case of Germany, even 90%.

So this is an [on-struggling] rate and we have to see, but we maintain our clear position that we see no reason to be fatalistic. We have the prime objective and products [for] generic to keep the volume and we succeed, but you need press for that and we have to see how this continues during the next months.

The most important factor for the growth rate in the second quarter and in the third quarter will be when and under which conditions generics will appear in France. We have today, now, as I speak, no generic in France, so our sales in France are relatively stable and the French market is a key market. It is, together with Germany, the largest Eloxatin market by far in Europe. And we have to see how the French market reacts.

So I am hesitating a little bit, but I would say that what you see this trimester should not be worse in the next trimester. But this is nothing but a guess.

Alexandra Hauber - Bear Stearns - Analyst

Thank you. That's very helpful.

Sanjay Gupta - Sanofi-Aventis - Head of IR

We just have time for --

Jean-Claude Leroy - Sanofi-Aventis - EVP Finance and Legal

No, I was [inaudible]. After a lot of work, I came to the conclusion that -- No, coming back to the SG&A line and the currency impact, I said that, with the impact of the U.S. dollar to euro taken into account, we could say that, starting from a minus 8.6% in SG&A line, we were back to between minus 1 [but] minus 5%. Because of the very great importance of the U.S. dollar in this area, I can confirm that, when you do the same work, including all the impacts of each and every currency, you come to the same conclusion. We are still within minus 4 and minus 5%.

Alexandra Hauber - Bear Stearns - Analyst

Okay, thank you.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Thank you. Claudia, we have time for a couple more questions, yes?

Operator

Thank you. We move to the next question from Jerome Berton with Aurel Leven. Please go ahead.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Jerome Berton - Aurel Leven - Analyst

Yes, good morning. Thank you for taking my question. Just really quickly, could you update us on the generic challenges on the CR version of Ambien? Have you [viewed] the generic challenges there?

And also, could you update us on the Japanese situation? If I remember correctly, Philippe Fauchet said in April that you could be interested in acquiring a mid-size company there. Could you confirm that or not?

And lastly, sorry if you already answer that, but could you explain or remember me the reason why Acomplia sales in the first quarter were a little bit, in my view, disappointing and lower than compared to the Q4? Thank you.

Hanspeter Spek - Sanofi-Aventis - EVP Operations

I start with Acomplia. We had some stocking effects in the fourth quarter, coming from a relatively intensive launch phase, really, at the end of the fourth quarter in various small markets, but it was more the number of markets. [We see them] in Europe, but not only in Europe. We had a number of launches, technical launches in December 2006, also, in South America, such as Mexico, Colombia and [Argentina]. So it is, to a certain extent, an [odd effect] and I believe that you will see much stronger figures, then, in the second quarter, of course, driven by the launch of Acomplia in France.

Concerning Philippe Fauchet's statement on an acquisition policy in Japan, yes, we confirm this. We believe that, despite the recent up-tick of our own internal performance and the additional external growth by products we are taking back from our Japanese partner, we still are under-represented in Japan. And, yes, of course, we are actively looking in Japan to opportunities which fit our needs. And those opportunities are more in the mid cap than in the large cap.

Now, on the Ambien CR, what we have done so far, we brought [suit] against Watson on January 26, 2007, against Synthron on February 5, 2007 and against Barr on April 5, also for 2007. We have received, paragraph four, notices for two other products coming from Anshun and [Aprica], but we have received those notices only in March and in April 2006, which means -- in 2006, which means, yes, we are fighting those applications.

We are going not further into details, but you may be aware that they are technical effects, which means that it is not useful to fight each and every applicant. So we have a selective legal strategy in this case, but we defend our rights, which we feel are solid. We have data exclusivity that precludes that the approval of any generic until March 2009 is literally impossible. And besides, we will defend our valid patents on the formulation, which will not expire before 2019.

Jerome Berton - Aurel Leven - Analyst

Okay, thank you.

Sanjay Gupta - Sanofi-Aventis - Head of IR

Last question please, Claudia.

Operator

Thank you. The last question comes from [Jo Walton] with Lehman Brothers. Please go ahead.

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Jo Walton - *Lehman Brothers - Analyst*

Good morning. I wonder if you could give us a little more help on Taxotere. You say that you've seen growth there, but it's still minimal growth in the U.S. If you could perhaps split out demand and price and give us some help?

And looking at restructuring, the EUR22m you had in the first quarter, you've alluded to some more to come in the second quarter and the second half. Is it fair to say that we should perhaps use this as an ongoing run rate for your continuing restructuring efforts?

Jean-Claude Leroy - *Sanofi-Aventis - EVP Finance and Legal*

I'll take the last one. Just to tell you, yes, I mentioned that rather small amount of Q1. And I said that we expect that [inaudible], which is going to be rather small, too, in Q2, but that doesn't give no guidance as to what you should see or you might see on this line item of restructuring on the ongoing year. So, no, it's not predictive of anything. It's just a conclusion of the total cost of this French restructuring, which, if we add up what happened in '06 and in the first quarter, brings the total to around EUR150m before tax.

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

And then, finally, Jo, on the Taxotere growth rate, yes, what you say is true. We have a much stronger growth still outside the U.S. with Taxotere. But let's keep in mind, if I remember correctly, our total in the U.S. for total 2006 has been close to zero. So in this respect, I see it as absolutely encouraging to report, now, a growth for the U.S. isolated of between 4 and 5%. So I see it as a good beginning and, yes, the international part, which is growing by 14% this year, is the right direction. But overall, I'm very much encouraged by what we see in the U.S. now.

Jo Walton - *Lehman Brothers - Analyst*

But the U.S. sales are still sequentially lower in the first quarter of this year than the fourth quarter of last year. So it doesn't look as if -- in dollar terms, so it doesn't look as if you've actually managed to turn the corner there.

Hanspeter Spek - *Sanofi-Aventis - EVP Operations*

Well, I see here a figure of EUR174m in the fourth quarter and EUR168m in the first quarter, so I think [inaudible] that it is, in absolute terms, on the same level, which, from quarter to quarter for a product which is centrally purchased like Taxotere, is, I believe, okay.

Jo Walton - *Lehman Brothers - Analyst*

Thank you.

Sanjay Gupta - *Sanofi-Aventis - Head of IR*

Thank you, Claudia, and thank you for participating in today's conference call. As usual, if you have any further questions, please don't call the IR team. Thank you. Goodbye.

FINAL TRANSCRIPT

May. 03. 2007 / 2:00AM, SNY - Q1 2007 Sanofi-Aventis Earnings & Sales Conference Call

Operator

Ladies and gentlemen, this will conclude today's conference call. Thank you for your participation. You may now disconnect.

DISCLAIMER

Thomson Financial reserves the right to make changes to documents, content, or other information on this web site without obligation to notify any person of such changes.

In the conference calls upon which Event Transcripts are based, companies may make projections or other forward-looking statements regarding a variety of items. Such forward-looking statements are based upon current expectations and involve risks and uncertainties. Actual results may differ materially from those stated in any forward-looking statement based on a number of important factors and risks, which are more specifically identified in the companies' most recent SEC filings. Although the companies may indicate and believe that the assumptions underlying the forward-looking statements are reasonable, any of the assumptions could prove inaccurate or incorrect and, therefore, there can be no assurance that the results contemplated in the forward-looking statements will be realized.

THE INFORMATION CONTAINED IN EVENT TRANSCRIPTS IS A TEXTUAL REPRESENTATION OF THE APPLICABLE COMPANY'S CONFERENCE CALL AND WHILE EFFORTS ARE MADE TO PROVIDE AN ACCURATE TRANSCRIPTION, THERE MAY BE MATERIAL ERRORS, OMISSIONS, OR INACCURACIES IN THE REPORTING OF THE SUBSTANCE OF THE CONFERENCE CALLS. IN NO WAY DOES THOMSON FINANCIAL OR THE APPLICABLE COMPANY ASSUME ANY RESPONSIBILITY FOR ANY INVESTMENT OR OTHER DECISIONS MADE BASED UPON THE INFORMATION PROVIDED ON THIS WEB SITE OR IN ANY EVENT TRANSCRIPT. USERS ARE ADVISED TO REVIEW THE APPLICABLE COMPANY'S CONFERENCE CALL ITSELF AND THE APPLICABLE COMPANY'S SEC FILINGS BEFORE MAKING ANY INVESTMENT OR OTHER DECISIONS.

©2007, Thomson Financial. All Rights Reserved.

Exhibit FF



Paris, May 3, 2007

Full-year guidance raised on good 2007 first-quarter results

Net sales (on a comparable basis):	up 6.9%
Adjusted EPS¹:	down 3.1%
Adjusted EPS¹ excluding selected items²:	up 11.0%

The consolidated income statement for the first quarter of 2007 is provided in the appendices. Consolidated net income after minority interests for the period was €1,537 million, compared with €1,512 million in the first quarter of 2006, after the impact of the accounting treatment of acquisitions (primarily the acquisition of Aventis) and associated after-tax restructuring costs totaling €580 million in the first quarter of 2007 and €661 million in the first quarter of 2006.

In order to give a better representation of our underlying economic performance, we have decided to present and explain an adjusted consolidated income statement¹ for the first quarter of 2007, and to compare it with an adjusted consolidated income statement for the first quarter of 2006. Adjusted net income for the first quarter of 2007 was €2,117 million, compared with €2,173 million for the first quarter of 2006.

Unless otherwise indicated, all sales growth figures in this press release are stated on a comparable basis¹.

FIRST QUARTER OF 2007:

- Net sales: €7,177 million, up 6.9% (up 2.0% on a reported basis). **Pharmaceuticals net sales growth was 6.2%, in line with the 2006 fourth-quarter growth rate.**
- **“Operating income – current”¹ up 12.4%. Improvement of 3.5 points in the ratio of “Operating income – current”¹ to net sales**
- Adjusted EPS of €1.57
- **11.0% growth in adjusted EPS excluding selected items² to €1.41, versus €1.27 for Q1 2006**

2007 GUIDANCE RAISED: Based on the good results achieved in the first quarter of 2007, the company has raised its 2007 full-year adjusted EPS growth guidance from 6% to 9% (excluding selected items^{2/3}).

Barring major adverse events (such as major adverse events on Lovenox® and Plavix® in the United States), the Group expects a growth in 2007 adjusted EPS excluding selected items in the range of 9%, calculated using a rate of €1 = \$1.25, despite the end of protection for Ambien® IR in the United States in April and the arrival of generic competition for Eloxatin® in Europe. Sensitivity to the euro/dollar exchange rate is estimated at 0.6% of growth for a 1-cent movement in the exchange rate⁴.

¹ Refer to the Appendix 1 for definitions of financial indicators

² See Appendix 5

³ Excluding selected items, 2006 adjusted EPS was 4.88 euros

⁴ Based on Q1 2007 average euro/dollar exchange rate (1 euro = 1,31), adjusted EPS growth guidance excluding selected items would be around 5.4%

2007 first-quarter net sales

In the first quarter of 2007, sanofi-aventis generated net sales of €7,177 million, an increase of 6.9%. Exchange rate movements had an unfavorable impact of 4.6 points, two-thirds of which related to the U.S. dollar. Changes in Group structure had an unfavorable effect of 0.3 of a point. On a reported basis, net sales rose by 2.0%.

Net sales by business segment - Pharmaceuticals

First-quarter net sales for the pharmaceuticals business were €6,610 million, an increase of 6.2%, in line with the growth rate for the fourth quarter of 2006. Net sales of the top 15 products were up 10.5% at €4,483 million, representing 67.8% of pharmaceuticals net sales compared with 65.2% in the first quarter of 2006.

€ million	Q1 2007 net sales	Change on a comparable basis
Lovenox®	634	+8.2%
Plavix®	569	-1.0%
Stilnox®/Ambien®/Ambien CR™	606	+49.3%
Taxotere®	449	+10.0%
Eloxatin®	393	-3.2%
Lantus®	458	+27.2%
Copaxone®	289	+17.5%
Aprovel®	264	+7.8%
Tritace®	211	-6.2%
Allegra®	201	+21.8%
Amaryl®	94	-19.0%
Xatral®	82	-9.9%
Actonel®	78	-10.3%
Depakine®	76	0.0%
Nasacort®	79	+21.5%
TOTAL TOP 15	4,483	+10.5%
TOTAL TOP 15 excluding Eloxatin® in Europe	4,374	+11.8%

First-quarter net sales of other pharmaceutical products fell by 1.8% to €2,127 million, against €2,165 million⁵ in 2006. Net sales of the antibiotic Ketek® halved year-on-year (to €30 million, from €59 million⁵ in the first quarter of 2006) due to restrictions on the indications for the product.

⁵ Q1 2006 comparable net sales

Geographical split of consolidated net sales by product (Top 15)

Q1 2007 net sales (€ million)	Europe	Change on a comparable basis	United States	Change on a comparable basis	Other countries	Change on a comparable basis
Lovenox®	186	+7.5%	385	+7.8%	63	+12.5%
Plavix®	423	+2.9%	22	-63.9%	124	+20.4%
Stilnox®/Ambien®/Ambien CR™	22	-8.3%	555	+54.2%	29	31.8%
Taxotere®	198	+13.8%	168	+4.3%	83	+13.7%
Eloxatin®	109	-24.3%	245	9.9%	39	0.0%
Lantus®	148	+14.7%	270	+31.7%	40	+53.8%
Copaxone®	78	+18.2%	197	+17.3%	14	+16.7%
Aprovel®	209	+5.0%	-	-	55	+19.6%
Tritace®	118	-11.9%	1	-75.0%	92	+5.7%
Allegra®	17	+21.4%	92	+21.1%	92	+22.7%
Amaryl®	32	-41.8%	2	-33.3%	60	+3.4%
Xatral®	44	-29.0%	25	+47.1%	13	+8.3%
Actonel®	51	-20.3%	-	-	27	+17.4%
Depakine®	53	-3.6%	-	-	23	+9.5%
Nasacort®	13	30.0%	60	+25.0%	6	-14.3%

Comments by product

Net sales of **Lovenox®**, the leading low molecular weight heparin on the market, reached €634 million in the first quarter, a rise of 8.2%. Growth of the product continues to be driven by its increasing use in medical prophylaxis.

Filing for approval of Lovenox® as a treatment for patients suffering from acute ST-segment elevation myocardial infarction (ExTRACT study) took place in the fourth quarter of 2006 in both Europe and the United States, where the FDA granted a priority review. This new indication is expected to further enhance the superiority of Lovenox over non-fractionated heparins.

The results of the PREVAIL study, showing the superiority of Lovenox® over unfractionated heparin for reducing the risk of venous thrombo-embolism in patients with acute ischemic stroke, were published in the April issue of The Lancet.

The results of the EXCLAIM study, which is examining the benefits of an extended Lovenox® regimen for prophylaxis of venous thrombo-embolism in medicalized patients, will be presented at the International Society of Thrombosis and Hemostasis (ISTH) Congress in July 2007.

Sales of **Plavix®** raw materials to the United States, which are consolidated by sanofi-aventis, remained weak in the first quarter (€22 million, down 64%) due to the availability in the United States of a generic version of clopidogrel bisulfate 75 mg tablets. Excluding this effect, consolidated net sales of Plavix® would have risen by 6.4% in the quarter.

First-quarter net sales of **Ambien® IR/Ambien CR™** in the United States rose by 54.2% to €555 million, a figure which includes €149 million for **Ambien CR™** (\$195 million). The market share of Ambien® IR /Ambien CR™ reached 46.3% in March (IMS NPA March 2007). At end March, prescriptions of Ambien CR™ represented 31.3% (IMS NPA weekly) of total Ambien® brand prescriptions.

Ambien® IR is facing competition from generics in the US, as its protection expired on April 20, 2007.

In Japan, sales of Myslee® (not consolidated by sanofi-aventis) reached €24 million in the first quarter, an increase of 8.4%.

Taxotere® reported strong first-quarter growth in “Other countries” (13.7%) and Europe (13.8%). In the United States, where the competitive environment remains challenging, net sales of the product rose by 4.3%. Taxotere® is now being sold in its two new indications (gastric cancer, head and neck cancer) in the United States and Europe.

In Europe, **Eloxatin®**, which is facing competition from generics in some countries (in particular Germany and the United Kingdom), reported a 24.3% decline in net sales to €109 million. In the United States, the product – which is still the market-leading colorectal cancer treatment both as adjuvant and in the metastatic phase – achieved further growth (of 9.9%, to €245 million).

Lantus®, the world’s leading insulin brand, continues to record excellent performances. Net sales of the product rose by 31.7% in the United States and 53.8% in “Other countries”. Solostar®, a new disposable pen that can be used to administer Lantus® and/or the rapid-acting insulin Apidra®, is gradually being rolled out across Europe from April, following the initial launch of Lantus® Solostar® in Germany. Solostar® reduces the force needed to inject insulin by 30% relative to the most commonly-available pens. It is also the only disposable multi-dose pen able to deliver doses of up to 80 units of insulin adjustable in 1-unit steps. Lantus® Solostar® has been approved by the FDA at the end of April.

Allegra® recorded a strong start to the year in Japan due to an early start to the pollen season.

As part of the agreements with Altana Pharma (member of the Nycomed group) concerning **Alvesco®** (ciclesonide) in the US, Sanofi aventis has informed its partner on April 17, 2007 of its decision to transfer back its rights related to **Alvesco®** (ciclesonide). The Group’s collaboration with Nycomed for the development and the commercialization of the combination product of ciclesonide with formoterol in the US continues.

Acomplia® is now available in over 10 European countries. It has been available in France since March 2007, and is reimbursable for obese patients with type 2 diabetes uncontrolled by metformin or sulphonylurea. In early April, the product was granted marketing approval in Switzerland and is reimbursed for the treatment of type 2 diabetics overweight patients and for the treatment of patients with obesity. At the end of April, Acomplia has been approved in Brazil for the treatment of obese patients, or overweight patients with associated risk factors, such as type 2 diabetes or dyslipidemia. Acomplia® is also available in Argentina, Mexico and Chile. First-quarter net sales totaled €15 million.

The SERENADE dossier was filed with the European healthcare authorities in December 2006 and with the FDA in February 2007. This study showed significant improvements in blood sugar control and weight, as well as in other risk factors such as HDL-cholesterol (good cholesterol) and triglycerides, when compared to placebo in type 2 diabetes patients not currently treated with anti-diabetic medications.

In the United States, rimonabant is on the agenda for the Endocrinologic and Metabolic Drugs Advisory Committee Meeting to be held on June 13, 2007. The FDA action letter is due on July 26, 2007.

Worldwide presence¹ of Plavix® / Iscover®:

€ million	Q1 2007	Change on a comparable basis
Europe	448	+5.4%
United States	603	-7.4%
Other countries	183	+18.1%
TOTAL	1,234	+0.2%

On August 8, 2006, Apotex announced that it had launched a generic version of clopidogrel bisulfate 75 mg tablets in competition with Plavix® in the United States. On August 31, 2006, the U.S. District Court for the Southern District of New York granted the motion filed by sanofi-aventis and Bristol-Myers Squibb for a preliminary injunction and ordered Apotex to halt sales of its generic version of clopidogrel bisulfate. However, the Court did not order the recall of products already sold by Apotex.

This preliminary injunction was upheld by the Court of Appeals for the Federal Circuit in December 2006. Consequently, U.S. sales of Plavix® rallied strongly in the first quarter of 2007 to €603 million (7.4% down versus the first quarter of 2006) after having been hit hard in the fourth quarter of 2006 (€273 million).

Total prescriptions (TRx) of clopidogrel bisulfate rose by 19.5%⁶ in the quarter thanks to sustained promotional activity. In addition, a recent FDA panel has recommended prolonged treatment for patients with drug eluting stents.

On April 18, 2007, a U.S. subsidiary of sanofi-aventis received a subpoena from the Attorney General of the State of New York requesting the production of certain documents relating to the proposed settlement of the U.S. Plavix® patent litigation against Apotex.

In Europe, first-quarter net sales of Plavix® were up 5.4% at €448 million, despite a further decline in German sales due to a marked slowdown in the market and the effect of parallel imports.

In Japan, the two-week limit on prescriptions imposed by the Japanese authorities will remain in force until May 2007. Quarterly sales of Plavix® totaled €4 million. The application relating to Plavix® as a treatment for acute coronary syndrome was filed with the Japanese authorities at the end of 2006.

Worldwide presence¹ of Aprovel®/Avapro®/Karvea®:

€ million	Q1 2007	Change on a comparable basis
Europe	227	+7.1%
United States	123	+15.0%
Other countries	93	+19.2%
TOTAL	443	+11.6%

In the first quarter of 2007, the worldwide presence of Aprovel®/Avapro®/Karvea® was represented by sales of €443 million, up 11.6%.

⁶ IMS NPA Q1 2007

Net sales of the product in the United States rose by 15.0% in the first quarter, largely as a result of higher selling prices. In the same period, total prescriptions of the product were stable⁶.

On April 18, the Cardio-Renal Advisory Committee of the FDA recommended approval of Avalide® as initial treatment of hypertension. Avalide® is a fixed-dose combination of irbesartan and hydrochlorothiazide that is currently approved for the treatment of hypertension in patients with blood pressure uncontrolled on monotherapy. If approved, the new indication for Avalide® would be the first-line treatment of hypertension in patients who are unlikely to obtain their blood pressure goals on monotherapy.

Net sales by business segment - Human Vaccines

First-quarter consolidated net sales for the human vaccines business were €567 million, an increase of 16.0%.

The strong increase in Adult Booster vaccines was a significant growth driver. Sales of Adacel™ (adolescent & adult tetanus-diphtheria-pertussis booster), launched in the United States in July 2005, reached €67 million for the quarter, up 133.3%. A new production facility, approved by the FDA in August 2006, has provided additional capacity to address the growing demand for Adacel™ and other pertussis vaccines.

Quarterly sales of influenza vaccines fell by 17.1% to €58 million. In the southern hemisphere, influenza vaccine sales rose by 14.4%, while sales fell in the United States based on a 2006 first-quarter comparative that was boosted by the extension of the 2005 vaccine campaign and stockpile purchases by the Centers for Disease Control and Prevention.

Menactra® reported net sales of €75 million, representing year-on-year growth of 53.7%, based on strong demand and increased availability of supply.

€ million	Q1 2007 net sales	Change on a comparable basis
Polio/Pertusis/Hib Vaccines	181	+1.1%
Adult Booster Vaccines	125	+64.5%
Influenza Vaccines	58	-17.1%
Travel & other Endemics Vaccines	80	+5.3%
Meningitis/Pneumonia Vaccines	89	+48.3%
Other Vaccines	34	+21.4%
TOTAL	567	+16.0%

First-quarter sales at Sanofi Pasteur MSD, the joint venture with Merck & Co in Europe, rose by 3.5% on a reported basis to €149 million. This trend reflects differences in the phasing of several tenders for inline vaccines relative to the same period in 2006.

Gardasil® is now marketed by Sanofi Pasteur MSD in 18 European countries including France, Germany, the United Kingdom and Italy. Spain will follow during 2007. To date, the authorities in Germany, France, Italy, Austria, Norway and Luxemburg have recommended the vaccination of girls and young women against human papillomavirus.

Sanofi Pasteur MSD sales are not consolidated by sanofi-aventis.

Net sales by geographic region

€ million	Q1 2007 net sales	<i>Change on a comparable basis</i>
Europe	3,113	-1.3%
United States	2,492	+16.4%
Other countries	1,572	+10.9%
TOTAL	7,177	+6.9%

In Europe, the healthcare reforms introduced in France and Germany during 2006 continued to depress sales, which fell by 1.3% year on year. Germany again reported a sharp fall, as parallel imports of Plavix® and Lovenox® continued. France is also experiencing negative growth, but was helped by winter pathologies. The gradual introduction of Eloxatin® generics across Europe accounted for 1% of the first-quarter decline in the region's net sales.

The United States reported robust sales growth in the first quarter, thanks largely to strong performances for Ambien®/Ambien CR™, Lantus®, and vaccines.

Growth in "Other countries" reached 10.9%, and was once again driven by Latin America and Asia.

2007 first-quarter adjusted consolidated income statement

The adjusted consolidated income statement is presented in Appendix 3.

Refer to Appendix 1 for a definition of “adjusted net income”, and to Appendix 4 for a reconciliation of the consolidated income statement to the adjusted consolidated income statement.

Net sales generated by sanofi-aventis in the first quarter of 2007 rose by 2.0% on a reported basis to €7,177 million.

Gross profit was €5,569 million. The gross margin ratio was unchanged relative to the first quarter of 2006 at 77.6%, reflecting two contrasting trends:

- a drop in “Other revenues” (royalties) from €289 million to €256 million, mainly as a result of the discontinuation of royalty income from Merial on Fipronil and the decline in sales of Plavix® in the United States because of competition from a generic version;
- an improvement of 0.5 of a point (to 26.0%) in the ratio of cost of sales to net sales, thanks to a favorable product mix.

Research and development expenses were 3.3% higher at €1,081 million (around 7% excluding currency impact).

Selling and general expenses were 8.6% lower than in the first quarter of 2006 at €1,873 million, equivalent to 26.1% of net sales (against 29.1% in the comparable period of 2006). As well as the weakness of the dollar against the euro during the first quarter of 2007, sanofi-aventis continued with the measures implemented in 2006 to adapt to the changing industry environment.

Other current operating income and expenses showed net income of €137 million, against €91 million in the first quarter of 2006.

Operating income – current¹ was up 12.4% at €2,719 million, equivalent to 37.9% of net sales, 3.5 points higher than in the first quarter of 2006.

A charge of €22 million was recognized in the first quarter of 2007 on the continuation of the restructuring plan initiated in France during 2006.

Operating income was €2,697 million, down 8.6%. This decrease was due to the fact that the 2006 first-quarter figure included net gains on disposals of €550 million, arising mainly on the disposals of the rights to Exubera® (€460 million, €384 million net of tax) and of the residual interest in the Animal Nutrition business (€45 million, €31 million net of tax).

Net financial expense came to €32 million, compared with €30 million in the first quarter of 2006. Interest expense on debt was €56 million, against €73 million in the comparable period of 2006.

Income tax expense was €595 million, compared with €832 million in the first quarter of 2006. The reported tax rate was 22.3%, against 28.5% for the comparable period of 2006. In 2007, this line included a net gain of €223 million related to net reversal of provisions for tax risks/resolution of tax audits, while in 2006 income tax expense was favorably impacted by the reduced tax rate charged on the gain on disposal of Exubera®. Excluding these two items, the effective tax rate was 30.7%, the same as in the first quarter of 2006.

The **share of profits from associates** was €159 million, compared with €181 million in the first quarter of 2006. This line was primarily affected by a drop in the share of after-tax profits from territories managed by BMS (primarily the United States) under the Plavix® and Avapro® alliance (€99 million, versus €113 million in the first quarter of 2006) due to the availability of a generic version in the United States.

Minority interests totaled €112 million, against €97 million in the first quarter of 2006. This line includes the share of pre-tax profits paid to BMS from territories managed by sanofi-aventis (€107 million, against €94 million in the first quarter of 2006).

Adjusted net income was down 2.6% at €2,117 million.

Adjusted earnings per share (EPS) was €1.57, 3.1% lower than the 2006 first-quarter figure of €1.62, based on an average number of shares outstanding of 1,351.1 million in the first quarter of 2007 and 1,344.4 million in the first quarter of 2006.

Adjusted net income excluding selected items (see Appendix 5) was €1,909 million, 11.8% higher than the 2006 first-quarter figure of €1,707 million.

Adjusted earnings per share excluding selected items (see Appendix 5) was €1.41, 11.0% higher than the 2006 first-quarter figure of €1.27.

Net debt, which was €5.8 billion at end December 2006, stood at €4 billion as of March 31, 2007.

2007 guidance raised

Based on the good results achieved in the first quarter of 2007, the company has raised its 2007 full-year adjusted EPS growth guidance from 6% to 9% (excluding selected items^{2/3}).

Barring major adverse events (such as major adverse events on Lovenox® and Plavix® in the United States), the Group expects a growth in 2007 adjusted EPS excluding selected items in the range of 9%, calculated using a rate of €1 = \$1.25, despite the end of protection for Ambien® IR in the United States in April and the arrival of generic competition for Eloxatin® in Europe. Sensitivity to the euro/ dollar exchange rate is estimated at 0.6% of growth for a 1-cent movement in the exchange rate⁴.

² See Appendix 5

³ Excluding selected items, 2006 adjusted EPS was 4.88 euros

⁴ Based on Q1 2007 average euro/dollar exchange rate (1 euro = 1,31), adjusted EPS growth guidance excluding selected items would be around 5.4%

Forward-Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives, intentions and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words “expect,” “anticipates,” “believes,” “intends,” “estimates,” “plans” and similar expressions. Although sanofi-aventis management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under “Risk Factors” and “Cautionary Statement Regarding Forward-Looking Statements” in the sanofi-aventis annual report on Form 20-F for the year ended December 31, 2006. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

Recent Events

February 12, 2007	Announcement of revisions to the prescribing information for Ketek® in the United States
February 13, 2007	Announcement that the review period for the Acomplia® filing in the United States had been extended by 3 months to July 26, 2007
February 23, 2007	Presentation to the ASCO Prostate Cancer Symposium of long term survival results from the TAX 327 Phase III clinical trial, which evaluated a Taxoter e® based regimen in patients with metastatic hormone refractory prostate cancer
March 16, 2007	Announcement that European launches of Lantus® SoloSTAR® and Apidra® SoloSTAR® would begin in April 2007
March 22, 2007	Announcement of reimbursable status for Acomplia® in France for obese patients with type 2 diabetes
March 26, 2007	Announcement that rimonabant had been put on the agenda for the Endocrinologic and Metabolic Drugs Advisory Committee Meeting to be held on June 13, 2007
March 28, 2007	Announcement by sanofi-aventis and Oxford BioMedica of the signature of an exclusive global license agreement to develop and commercialize TroVax® for the treatment and prevention of cancers
March 30, 2007	Announcement of an update to the European Summary Of Product Characteristics (SmPC) for Ketek®
April 2, 2007	Announcement of the transfer of all the commercial rights for Panaldine® in Japan from Daiichi to sanofi-aventis
April 3, 2007	Announcement of marketing approval for Acomplia® in Switzerland
April 17, 2007	Announcement of approval by the FDA of the sanofi pasteur H5N1 vaccine
April 20, 2007	Announcement of publication of the PREVAIL study (Prevention of VTE after Acute Ischemic Stroke with LMWH Enoxaparin) in the April issue of <i>The Lancet</i> .
April 20, 2007	Announcement of reimbursement of Acomplia® (rimonabant) in Switzerland for the treatment of Type 2 Diabetics Overweight Patients and for the treatment of Patients with Obesity
April 26, 2007	Announcement of approval of Acomplia® in Brazil for the treatment of obese patients, or overweight patients with associated risk factors, such as type 2 diabetes or dyslipidemia
April 30, 2007	Announcement of approval of Lantus®SoloSTAR® by the FDA

Financial Timetable

May 31, 2007	Shareholders' Annual General Meeting
August 1, 2007	2007 second-quarter sales and results
September 17, 2007	Research and Development meeting
October 31, 2007	2007 third-quarter sales and results

Appendices

List of Appendices

- Appendix 1: Explanatory notes/ Financial indicators
- Appendix 2: 2007 first-quarter net sales by product
- Appendix 3: 2007 first-quarter adjusted consolidated financial statements
- Appendix 4: 2007 first-quarter reconciliation of consolidated income statement to adjusted consolidated income statement
- Appendix 5: Trends in selected adjusted income statement items, net of tax

Appendix 1: Explanatory notes/ Financial indicators

Comparable net sales

When we refer to the change in our sales on a “comparable” basis, we mean that we exclude the impact of exchange rate movements and changes in Group structure (acquisitions and divestments of interests in entities and rights to products, and changes in consolidation method for consolidated entities).

We exclude the impact of exchange rates by recalculating sales for the prior period on the basis of exchange rates used in the current period. We exclude the impact of acquisitions by including sales from the acquired entity or product rights for a portion of the prior period equal to the portion of the current period during which we owned them, based on sales information we receive from the party from whom we make the acquisition.

Similarly, we exclude sales in the relevant portion of the prior period when we have sold an entity or rights to a product.

For a change in consolidation method, the prior period is recalculated on the basis of the method used for the current period.

Reconciliation of 2006 first-quarter net sales to 2006 first-quarter comparable net sales

€ million	Q1 2006
Q1 2006 net sales	7,035
Impact of changes in Group structure	(16)
Impact of exchange rates	(308)
Q1 2006 comparable net sales	6,711

Worldwide presence of a product

When we refer to the “worldwide presence” of a product, we mean our consolidated net sales of that product, minus sales of the product to our alliance partners plus non-consolidated sales made through our alliances with Bristol-Myers Squibb on Plavix®/Iscover® (clopidogrel) and Aprovel®/Avapro®/Karvea® (irbesartan), based on information provided to us by our alliance partner.

Operating income – current

We define “operating income – current” as operating income before restructuring, impairment of property, plant and equipment and intangibles, gains/losses on disposals, and litigation.

Adjusted net income

We define “adjusted net income” as accounting net income after minority interests (determined under IFRS) adjusted to exclude (i) the material impacts of the application of purchase accounting to acquisitions and (ii) acquisition-related integration and restructuring costs. Sanofi-aventis believes that eliminating these impacts from net income gives investors a better understanding of the underlying economic performance of the combined Group.

The material impacts of the application of purchase accounting to acquisitions, primarily the acquisition of Aventis, are as follows:

- Charges arising from the remeasurement of inventories at fair value, net of tax;
- Amortization/impairment expense generated by the remeasurement of intangible assets, net of tax;
- Any impairment of goodwill.

Sanofi-aventis also excludes from adjusted net income any integration and restructuring costs (net of tax) that are specific to the acquisition of Aventis by sanofi-aventis.

€ million	Q1 2007 Consolidated financial statements (unaudited)	Q1 2007 Adjusted consolidated financial statements (unaudited)
Net sales	7,177	7,177
Net income after minority interests	1,537	2,117
Basic earnings per share	1.14	1.57

Appendix 2: 2007 first-quarter net sales by product

€ million	Q1 2007 net sales	Q1 2006 comparable net sales	Q1 2006 reported net sales
Lovenox®	634	586	624
Plavix®	569	575	580
Stilnox®/Ambien®/Ambien CR™	606	406	441
Taxotere®	449	408	430
Eloxatin®	393	406	429
Lantus®	458	360	382
Copaxone®	289	246	263
Aprovel®	264	245	248
Tritace®	211	225	235
Allegra®	201	165	180
Amaryl®	94	116	121
Xatral®	82	91	94
Actonel®	78	87	89
Depakine®	76	76	78
Nasacort®	79	65	71
TOTAL	4,483	4,057	4,265
Other products	2,127	2,165	2,258
TOTAL Pharmaceuticals	6,610	6,222	6,523
Vaccines	567	489	512
TOTAL Net sales	7,177	6,711	7,035

Appendix 3: 2007 first-quarter adjusted consolidated financial statements**2007 first-quarter adjusted consolidated financial statements (unaudited)**

€ million	Q1 2007 Adjusted consolidated income statement (unaudited)	as % of net sales	Q1 2006 Adjusted consolidated income statement (unaudited)	as % of net sales	% change
Net sales	7,177	100.0%	7,035	100.0%	+2.0%
Other revenues	256	3.6%	289	4.1%	-11.4%
Cost of sales	(1,864)	(26.0%)	(1,867)	(26.5%)	-0.2%
Gross profit	5,569	77.6%	5,457	77.6%	+2.1%
Research and development expenses	(1,081)	(15.1%)	(1,046)	(14.9%)	+3.3%
Selling and general expenses	(1,873)	(26.1%)	(2,050)	(29.1%)	-8.6%
Other current operating income	191	-	119	-	-
Other current operating expenses	(54)	-	(28)	-	-
Amortization of intangibles	(33)	-	(33)	-	-
Operating income – current*	2,719	37.9%	2,419	34.4%	+12.4%
Restructuring costs	(22)	-	-	-	-
Impairment of PP&E and intangibles	-	-	(1)	-	-
Gain/loss on disposals, and litigation	-	-	533	-	-
Operating income	2,697	37.6%	2,951	41.9%	-8.6%
Financial expenses	(83)	-	(109)	-	-23.9%
Financial income	51	-	79	-	-35.4%
Income before tax and associates	2,665	37.1%	2,921	41.5%	-8.8%
Income tax expense	(595)	(8.2%)	(832)	(11.8%)	-28.5%
Reported tax rate	22.3%	-	28.5%	-	-
Share profit/loss of associates	159	-	181	-	-12.2%
Consolidated net income	2,229	31.1%	2,270	32.3%	-1.8%
Minority interests	112	-	97	-	+15.5%
Net income after minority interests	2,117	29.5%	2,173	30.9%	-2.6%
Average number of shares outstanding (millions)	1,351.1		1,344.4		
Earnings per share (in euros)	1.57		1.62		-3.1%

*Operating income before restructuring, impairment of PP&E and intangibles, gains/losses on disposals, and litigation

Appendix 4: 2007 first-quarter reconciliation of consolidated income statement to adjusted consolidated income statement

The adjustments to the income statement reflect the elimination of material impacts of the application of purchase accounting to acquisitions, primarily the acquisition of Aventis, amounting to €580 million net of deferred taxes (with no cash impact for the Group).

€ million	Q1 2007 Consolidated (unaudited)	Adjustments	Q1 2007 Adjusted consolidated (unaudited)
Net sales	7,177		7,177
Other revenues	256		256
Cost of sales	(1,864)		(1,864)
Gross profit	5,569		5,569
Research and development expenses	(1,081)		(1,081)
Selling and general expenses	(1,873)		(1,873)
Other current operating income	191		191
Other current operating expenses	(54)		(54)
Amortization of intangibles	(919)	886 ^(a)	(33)
Operating income – current*	1,833	886	2,719
Restructuring costs	(22)		(22)
Impairment of PP&E and intangibles	-		-
Gain/loss on disposals, and litigation	-		-
Operating income	1,811	886	2,697
Financial expenses	(83)		(83)
Financial income	51		51
Income before tax and associates	1,779	886	2,665
Income tax expense	(268)	(327) ^(b)	(595)
Share profit/loss of associates	138	21 ^(c)	159
Consolidated net income	1,649	580	2,229
Minority interests	112		112
Net income after minority interests	1,537	580	2,117
Average number of shares outstanding (millions)	1,351.1		1,351.1
Earnings per share (in euros)	1.14	0.43	1.57

*Operating income before restructuring, impairment of PP&E and intangibles, gains/losses on disposals, and litigation

The material impacts of the application of purchase accounting to acquisitions (primarily the acquisition of Aventis) on the 2007 first-quarter consolidated income statement are:

- a) An amortization charge of €886 million against intangible assets. This adjustment has no cash impact on the Group.
- b) Deferred taxes of €327 million generated by the amortization charge of €886 million taken against intangible assets. This adjustment has no cash impact on the Group.
- c) In “Share of profit/loss from associates”, a €21 million charge corresponding to amortization and impairment of intangibles (net of tax). This adjustment has no cash impact on the Group.

Appendix 5: Trends in selected adjusted income statement items, net of tax

€ million	Q1 2007	Q1 2006
Restructuring costs	(15)	-
Net gains/(losses) on disposals	-	446 ²
Provisions for financial instruments , litigation, tax inspections and other items	223 ¹	20
TOTAL after tax	208	466

¹ Net reversal of provisions for tax risks/settlement of tax audits: €223 million

² including:

- Exubera®: €384 million
- Animal Nutrition: €31 million

REMINDER**8.00 am CET - WEBCAST
& CONFERENCE CALL (English)**

The 1st quarter 2007 sales and earnings will be reviewed today by Mr. Hanspeter Spek, Executive Vice-President, Pharmaceutical Operations, Mr. Jean-Claude Leroy, Executive Vice President, Finance and Legal. The slides will be available on <http://www.sanofi-aventis.com>. This presentation will be followed by a Q&A session.

CALL-IN NUMBERS

The conference will also be available by telephone via the following numbers:

France +33 (0) 1 70 99 42 87
 UK +44 (0) 207 138 0843
 USA +1 718 354 1152

AUDIO REPLAY

Available online at <http://www.sanofi-aventis.com> and through the numbers below (until May 12, 2007):

France +33 (0) 1 71 23 02 48
 UK +44 (0) 207 806 1970
 USA +1 718 354 1112
 Access code 3947621#

Investor Relations Department
 Paris: +33 (0)1.53.77.45.45 – Bridgewater: +1.908.981.5560
 Email: IR@sanofi-aventis.com

Exhibit GG



FDA ADVISORY COMMITTEE DID NOT RECOMMEND APPROVAL OF RIMONABANT (ZIMULTI®) FOR USE IN OBESE AND OVERWEIGHT PATIENTS WITH ASSOCIATED RISKS FACTORS

Paris, France - June 13, 2007 – Sanofi-aventis announced today that the U.S. Food and Drug Administration (FDA) Endocrinologic and Metabolic Drugs Advisory Committee did not recommend approval of rimonabant (ZIMULTI®) to the US FDA for use in obese and overweight patients with associated risks factors.

Sanofi-aventis will continue to work closely with the FDA to address the committee's recommendations.

The FDA has set a PDUFA action date of July 26, 2007 for rimonabant.

Rimonabant is currently approved in 37 countries and is marketed in 18. In those countries where it is currently sold, the product is marketed as ACOMPLIA®.

About Rimonabant

Rimonabant is the first and the most studied member of a new therapeutic class of drugs that selectively block the CB₁ receptors of the endocannabinoid system (ECS), and the drug's development has deepened scientists' understanding of the ECS. When working normally, this system of receptors in the brain and throughout the body (liver, muscle, abdominal adipose tissue, gastro-intestinal tract and pancreas), among other functions, helps regulate food intake and how the body uses and stores fats and sugars.

Rimonabant, and its effects on the ECS, have been extensively studied, resulting in well-defined efficacy and safety profiles. The Committee reviewed findings from a comprehensive clinical trials program that included data from 59 completed clinical studies enrolling more than 15,000 patients.

Additional safety data were presented from ongoing clinical studies and more than 110,000 individuals in Europe and other countries who have taken rimonabant.

The most common adverse events associated with rimonabant were consistent across studies and included gastrointestinal (nausea, vomiting, diarrhea), nervous system (headache, dizziness, paresthesia/hypoesthesia/dysesthesia) and psychiatric disorders (anxiety, insomnia, depressed mood and depression). These adverse events generally occurred within the first 2-3 months, and were often mild to moderate in intensity.



About sanofi-aventis

Sanofi-aventis is one of the world's leading pharmaceutical companies, ranking number one in Europe. Backed by a world-class R&D organization, sanofi-aventis is developing leading positions in seven major therapeutic areas: cardiovascular, thrombosis, oncology, metabolic diseases, central nervous system, internal medicine and vaccines. Sanofi-aventis is listed in Paris (EURONEXT: SAN) and in New York (NYSE: SNY).

Forward Looking Statements

This press release contains forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995, as amended. Forward-looking statements are statements that are not historical facts. These statements include financial projections and estimates and their underlying assumptions, statements regarding plans, objectives, intentions and expectations with respect to future events, operations, products and services, and statements regarding future performance. Forward-looking statements are generally identified by the words "expects," "anticipates," "believes," "intends," "estimates," "plans" and similar expressions. Although sanofi-aventis' management believes that the expectations reflected in such forward-looking statements are reasonable, investors are cautioned that forward-looking information and statements are subject to various risks and uncertainties, many of which are difficult to predict and generally beyond the control of sanofi-aventis, that could cause actual results and developments to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include those discussed or identified in the public filings with the SEC and the AMF made by sanofi-aventis, including those listed under "Risk Factors" and "Cautionary Statement Regarding Forward-Looking Statements" in sanofi-aventis' annual report on Form 20-F for the year ended December 31, 2006. Other than as required by applicable law, sanofi-aventis does not undertake any obligation to update or revise any forward-looking information or statements.

US Media Relations:

Julissa Viana: +1 908-981-6575 / Email: julissa.viana@sanofi-aventis.com

Lisa Kennedy: +1 908-981-6569 / Email: lisa.a.kennedy@sanofi-aventis.com

Press Release